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ROYAL COMMISSION ON HEALTH SERVICES

ORGANIZED COMMUNITY HEALTH SERVICES

J.E.F. Hastings
W. Mosley

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PREFACE

SCOPE AND PURPOSES OF THE STUDY

A wide variety of organized health services and facilities have been established in Canadian communities over the years. With some exceptions, the trend has been for each programme to be developed independently in response to a particular health problem and without much consideration of its impact on other health services and on the overall pattern of community health services. Thus, in any one community, services and facilities may be provided by agencies of the Dominion, provincial, and municipal governments, by a wide variety of lay and religious voluntary organizations, and by proprietary agencies. In an era when medical science and technology and socio-economic changes have combined to produce a rapid proliferation of health programmes and facilities, there is growing concern over the effects of a largely unco-ordinated development of community health services. The resultant overlapping of service in some areas, gaps in service in other areas, and uneconomic use of skilled personnel and complex facilities, together with a tendency to overlook regular, objective evaluation of programmes, are hindering the provision of a balanced pattern of services for improving the health of the Canadian people.

It is the general purpose of this project to observe, study, and make suggestions about organized community health services, whether they are provided under official or voluntary auspices or a combination of auspices. The scope, therefore, covers the public health department or health unit, the hospitals and related institutional facilities, rehabilitation, mental health, home care, ambulance services, health services for the aged, and the voluntary health agencies. In so far as they are related to the effective provision of the organized health services, the work of practising physicians and dentists and the services of official and voluntary social welfare agencies come within the project's scope. Finally, it is necessary to look at the relationship of community services to those provided on provincial and national bases.

The specific purposes of the study are:

1. To outline the current picture of organized community health services.
2. To judge the extent and kinds of such services needed at present.
3. To make suggestions for the future development of organized community health services.
4. To suggest ways for co-ordinating more effectively the planning and provision of organized community health services.

5. To suggest ways for improving the co-ordination of organized community health services with other health and welfare services.

THE STUDY METHOD

Field studies of the health service patterns in four Ontario communities were carried out. The communities studied were selected as examples of four different types of community: a large metropolitan area,¹ a medium-sized city,² a rural small town area,³ and a semi-isolated area.⁴ It is not contended that they are either "average" or "typical" in the strict research sense. Although only four field studies could be made because of limitations of available personnel, time, and finances, it is felt that they serve as useful general illustrations of the kinds of problems which arise in providing organized health services in different types of community.

Three of the study descriptions are based on personal visits to such people and agencies as the official health department or unit, members of the local board of health, the municipal clerk-treasurer, the hospitals, the local medical and, where possible, dental society officers, official welfare officials, voluntary health and social service organizations, facilities and services for special groups of people, for example, the aged and those needing rehabilitation, education authorities, and other knowledgeable citizens.

The method of study had to be altered for Metropolitan Toronto because of the multiplicity of organizations, both official and voluntary, which provide health services in the area. Except for the public health departments and units to which specific visits were made, sources of collected information and personal knowledge of the area were used. Only the work of the local public health departments has been described in the Toronto study, since extensive, published information is readily available on other health and welfare services in Metropolitan Toronto.

The detailed field study descriptions and directly related comments have been placed in appendixes, since they are meant to serve primarily as illustrations.⁵ In the body of the study only brief summaries of the various organized community health services are presented, together with a discussion of problems and issues related to the present and future provision of the services.⁶ A number of suggestions arising from our consideration of the findings are presented both where they arise in the discussion of specific health services and also in summary form in Chapter V.⁷ The main administrative suggestion, to which frequent general references are made in Chapters I-III, is presented in broad outline in Chapter IV.⁸

¹Metropolitan Toronto.

²Peterborough.

³Huron County.

⁴District of Timiskaming.

⁵Appendix I, Peterborough, pp. 173-218. Appendix II, Huron County, pp. 219-261. Appendix III, District of Timiskaming, pp. 263-297. Appendix IV, Metropolitan Toronto, pp. 299-317.

⁶Part I, Chapters I-III, pp. 11-68.

⁷Chapter V, pp. 75-87.

⁸Chapter IV, pp. 69-73.

For reasons of limited staff, time, and finances and also to eliminate interprovincial variations as influences on comparisons among the study communities themselves, it was decided to conduct the field studies in one province, Ontario. A basic assumption in using this approach was that, although there may be considerable variation from province to province in the precise administrative structures for providing any specific service, the basic kinds of organized service in communities of comparable size and nature are broadly similar. There are issues and problems of planning, organization, staffing, financing, and co-ordination, whatever the administrative pattern.

A working document, describing the findings and problems in Ontario, together with preliminary suggestions, was sent to each of the provincial deputy ministers of health and to the senior hospital plan administrator in any province where the provincial hospital plan administration is separate from the provincial Department of Health. The accompanying letter described the purpose of the study and stressed the awareness of the authors that differences in administrative patterns for public health and other services affect some of the problems and issues to be found. Comments were requested on the problems, issues, and suggestions presented in the working document, as they might or might not be relevant for the provinces other than Ontario. It was also made clear that any comments would remain anonymous.

In addition, each deputy minister received a summary outline of organized community health services in his province, as prepared from available sources. It was requested that the outline be added to and otherwise corrected, so that a fair and accurate "capsule view" of service patterns in each province would result. The factual summaries were subsequently added to by the authors to make the outlines of services more comprehensive. The descriptive outlines are presented in Chapter VI of this study,¹ together with the comments received on the relevance of the study findings and suggestions to the other provinces.

Finally, the working document was also sent for comments to selected people outside the provincial administrations in the various provinces. Their comments are also included anonymously in Chapter VI.²

In spite of obvious reservations about the study approach, the generally warm and frank responses of our colleagues in the other provinces indicate that the basic assumption was sound. Definite administrative differences exist from province to province but many, if not most, of the problems and issues are common. In the replies general administrative differences were indicated and in most instances valuable comments were made on our main administrative suggestion and on many of the specific programme suggestions. *It is, however, our firm opinion, that it would be desirable to carry out similar studies in each of the other provinces.*

From a consideration of the community health service patterns in the provinces other than Ontario and of the comments received, some general

¹Chapter VI, pp. 91-165.

²*Ibid.*

comments only on the suggestions made for Ontario, as they may or may not be relevant for the other provinces, have been presented in Chapter VII.¹

SPECIAL ACKNOWLEDGEMENTS

A study, such as this one, depends on the co-operation and assistance of many people. In the Acknowledgements² we have listed the names of those who helped us. Mere words cannot express the debt of appreciation which we owe each of them.

We wish in particular to thank the University of Toronto and the East York-Leaside Health Unit Board of Health for permitting us to undertake the project. Special appreciation is also due to Dr. Robert Aldis, the Director and Medical Officer of Health of the Huron County Health Unit, Dr. James Anderson, the Medical Officer of Health for the City of Peterborough, and Dr. Ross Harris, the Director and Medical Officer of Health of the Timiskaming Health Unit, who not only assisted us in studying their own specific programmes but also made the arrangements for the three field studies outside Metropolitan Toronto. Their guidance made our task easier and their hospitality added greatly to our pleasure.

Several of our colleagues at the University of Toronto gave generously of their experience, counsel, and time in reading and commenting on the various drafts of sections of the report. In particular, we wish to express appreciation to Dr. A. J. Rhodes, the Director of the School of Hygiene, Dr. M. H. Brown, the Professor and Head of the Department of Public Health, Dr. W. H. le Riche, the Professor and Head of the Department of Epidemiology and Biometrics, Dr. F. B. Roth, the Professor and Head of the Department of Hospital Administration, Professor J. S. Morgan, Professor of Social Work in the School of Social Work, Professor E. M. Stuart, Professor of Hospital Administration, Dr. C. W. Schwenger, Associate Professor of Public Health Practice, Dr. S. A. MacGregor, Professor of Paedodontia, Faculty of Dentistry, Dr. K. C. Clute, Director of Research in the Department of Public Health, and Dr. C. C. Love, Professor of English at Victoria College, University of Toronto.

Mrs. I. Allward, the secretary of the Department of Public Health, gave valued assistance and advice on arrangements throughout the time of the study. Special debts of thanks are owed to Miss G. Weaver, the project secretary, and to Miss S. McCausland for their typing of the various drafts of the study and for their tolerant understanding of the pressures involved in carrying out such a study.

Finally, we wish to thank Professor B. R. Blishen and his associates on the Research Staff of the Royal Commission on Health Services for their guidance and support.

¹Chapter VII, pp. 167-169.

²See Acknowledgements, pp. 319-323.

We wish to emphasize that the comments and suggestions in this study are our responsibility alone. We hope that those who have assisted us and that those who may read the study will forgive us for any inadvertent inaccuracies and omissions which it may contain.

February 28, 1963.

John E. F. Hastings, M.D., D.P.H.
William Mosley, M.D., D.P.H.

INTRODUCTION—THE EVOLUTION OF ORGANIZED COMMUNITY HEALTH SERVICES IN CANADA¹

THE COLONIAL PERIOD

From the first years of European settlement in Canada there were health problems of a nutritional nature, such as scurvy, and epidemics such as smallpox. From time to time, ordinances were enacted in an effort to control some of the problems. Thus, in 1707, a law to control the sale of meat in Quebec was proclaimed and, about the same time, other ordinances concerned such matters as the cleanliness of streets and private dwellings. In 1721, a quarantine station for ships was established at Isle aux Coudres. However, periodic outbreaks of epidemic disease and nutritional problems continued to bring much suffering and death to the settlers and to the indigenous Indians.

Under the auspices of orders of the Roman Catholic Church, hospitals were founded for the care of the sick and injured. The first was the Hotel-Dieu in Quebec in 1639. This was followed by the Hotel-Dieu in Montreal in 1644. Two small buildings for the insane were built in 1714 in Quebec, and, later, limited facilities were provided in Montreal. Some mentally ill people were believed to have been sent back to France. Ships surgeons and apothecaries are known to have been members of the early groups who came to Canada. The first permanent surgeon-apothecary seems to have been Louis Hebert who came to Quebec in 1617 as resident physician and surgeon and who also gained fame as the first permanent farmer.²

It is also noteworthy that from 1608, the parochial registration of births, marriages, and deaths was required and that from 1667 a duplicate copy was sent to the Juge Royal.

¹The sources of historical information presented in this chapter, unless specifically noted, are: John J. Heagerty, *Four Centuries of Medical History in Canada*. (Toronto: The Macmillan Company of Canada Limited, 1928.). Peter H. Bryce, "The Story of Public Health in Canada," *A Half Century of Public Health*, ed. Mazyck P. Ravenel (New York: American Public Health Association, 1921), p. 56. *The Federal and Provincial Health Services in Canada*, ed. R. D. Defries (2d. ed. rev.; Toronto: Canadian Public Health Association, 1962). Canada, Department of National Health and Welfare, Research and Statistics Division, *The Administration of Public Health in Canada*, Health Care Series, Memorandum No. 3, 1958.

²In 1606-07, he had spent a winter at Port Royal in Acadia (now part of Nova Scotia).

During the British colonial period little interest was shown in organized community health measures until the first part of the nineteenth century. In some urban centres there was periodic enforcement of general regulations on cleanliness and the sale of food products. Gradually, additional hospitals were founded under both religious and lay auspices. Doctors, of whatever training, were few and far between. Except in the larger communities, most people were born, lived, and died without the benefits, such as they were, of trained medical help. In Nova Scotia, registration of births, marriages, and deaths was required from 1761. A port quarantine act for Halifax was enacted in the same year. In 1795, an act was passed in Lower Canada to permit ships to be quarantined. It is known that individual smallpox vaccinations, using vaccine lymph obtained from England, were carried out by doctors in Quebec and in Yarmouth in 1801-02. In 1821, a Vaccine Institute was established in Lower Canada. However, vaccination did not become a general practice for some years to come. Smallpox and other epidemic diseases continued to produce periodic havoc among the growing colonies.

The outbreak of a massive cholera epidemic in 1832, following the arrival of large numbers of Irish immigrants seeking to escape the famine and appalling living conditions in their own land, led to the first widespread public health measures. The seaports were ill-equipped to cope with the deluge of sick and dying people and the hospital and medical resources were soon overwhelmed. The epidemic spread rapidly to the people of the colonies. A board of health was set up at Quebec and a maritime quarantine station at Grosse Isle nearby. The legislatures of Lower Canada, Nova Scotia, New Brunswick, Upper Canada, and Newfoundland passed legislation in 1832-33 for the establishment of local boards of health¹ in an effort to control the outbreak. However, these boards were not permanent and once the outbreak had subsided they became inactive.

An outbreak of typhus fever in 1847 and the re-appearance of cholera in epidemic form in 1849 caused the newly established parliament of the united provinces of Upper and Lower Canada to establish a Central Board of Health. Under the legislation, in any area designated by proclamation, the chief municipal officer was empowered to constitute a local board of health. In turn such a board was required to appoint a medical officer of health to combat the epidemic. As in the earlier instances, the measures were regarded as emergency ones to be enforced only when an outbreak existed or was likely to occur.

A few urban centres, such as Quebec in 1840, gradually established permanent boards. After further serious cholera epidemics in 1854 and 1865, further local boards remained active, but most ceased to function once the threat had eased.

At the time of Confederation in 1867 the main problems of the public health in Canada were the recurring epidemics of communicable diseases, such as cholera, typhus, and smallpox. The only major control technique was maritime quarantine. Provision was also made for rudimentary facilities for the care for those who became ill and for assuring proper burial of those who died. Otherwise public health was considered to be purely of local concern about matters, such as the control of filth and smells and the provision of basic medical

¹For example, in 1833 a board of health was established for Toronto and the surrounding area.

relief for the poor. The extent of interest in implementing even these measures varied widely from one community to another.

Hospitals were gradually established in the larger communities under either religious or lay, voluntary auspices. They served chiefly the poorer groups in society and were regarded as a place of last resort because of the high mortality among those who entered them. Surgery was extremely hazardous at best; in hospital there was an added risk of post-operative infection. Skilled nursing was non-existent. People who could do so arranged for care at home.

In Lower Canada, the care of the mentally ill was entrusted to religious communities and to families to whom they were "farmed out" under contract. Elsewhere early facilities for care were the poorhouses and jails. In 1841, the old jail in Toronto and subsequently part of the old parliament buildings were taken over for this purpose. An asylum was built in 1850 and thereafter over the next decade several more were constructed. Asylums were built in 1845 at St. John's, Newfoundland, in 1847 near Charlottetown, in 1848 at Saint John, New Brunswick, and in 1857 near Halifax. Although these were some improvement on the earlier improvised jail and poorhouse facilities, conditions were generally harsh and the care was restrictive and custodial in nature. Here and there, enlightened directors, such as Dr. Joseph Workman in Toronto, succeeded in introducing reforms to alleviate some of the more harsh aspects of care.

THE LATE NINETEENTH AND EARLY TWENTIETH CENTURIES

The British North America Act of 1867, which created the Dominion of Canada, made few specific references to matters of health. Sections 91 and 92 placed responsibility for "quarantine and the establishment and maintenance of marine hospitals" on the Dominion Government and powers related to "the establishment, maintenance and management of hospitals, asylums, charities and eleemosynary institutions in and for the provinces, other than marine hospitals" were assigned to the provinces. Subsequent constitutional interpretations have placed the major responsibility for health measures and services on the provinces.

The middle and later years of the nineteenth century saw a radical change in man's knowledge of disease causation and the development of organized community health measures. During the early years of the Industrial Revolution in Britain, there was gradually increasing concern over the appalling living conditions of workers in the industrial cities and over the accompanying fearful toll of human life and industrial productivity. This period also coincided with the religious revival and the work of the great reformers, such as Wilberforce. In 1842 Edwin Chadwick's "Report on the Sanitary Condition of the Labouring Population of Great Britain" for the House of Commons pointed out in dramatic terms the extent of the horrible conditions under which the poorer people lived and their markedly lower life expectancy as opposed to the middle and wealthier groups in society. As a result various health measures were passed and these finally resulted in the establishment of a central health authority which in turn placed responsibility on the local municipalities for matters of public health. The culmination of these moves was the passage of the English Public Health Act of 1875.

The Public Health Act in the United Kingdom in 1875 had a marked influence in Canada. Each province, starting with Ontario in 1884, passed a Public Health Act, essentially based on the British Act. These Acts required every municipality to appoint a local board of health, a medical officer of health, and a sanitary inspector. As the western provinces developed, they too passed public health legislation. Previously some of the larger cities had appointed medical officers of health, usually on a temporary basis, as were the boards of health established from time to time to combat epidemics. Under the new legislation, the appointments were of a permanent nature. Concern was chiefly with the control of communicable diseases, environmental sanitation, and the provision of medical assistance for the poor.

The latter part of the last century also saw the great discoveries by Pasteur and his successors. Their work led, over succeeding years, to the development of specific regulatory measures and of specific biological products which could be used on a community-wide basis for the prevention and control of many communicable diseases. Thus, during the early decades of the present century, organized public health services through the establishment of safe water supplies, of pasteurization of milk, of food control, and of other environmental control measures and through the wide-spread use of preventive inoculations were able to make dramatic headway against the epidemic scourges which for so long had plagued man.

Hospitals too felt the impact of change. The earlier work of men such as Semmelweiss and Lister when linked with Pasteur's discovery resulted in the trend to antiseptic and, in time, to aseptic hospital techniques. Florence Nightingale and her successors altered hospitals in design and internal functioning and changed nursing into a skilled profession. In 1873, Dr. Mack started the first professional nursing course in Canada at the General and Marine Hospital in St. Catharines, Ontario. Surgical and anaesthetic methods also improved and gradually have lost much of the risk formerly associated with them. As the West was opened up and new provinces became a part of the Dominion, hospitals also were established in these areas. Although many were operated by religious orders or on a lay, voluntary basis as in the East, many others were built and operated by municipalities or by a combination of municipalities as union hospitals.

Except in Quebec, mental hospitals continued to be a provincial responsibility. In 1897, the Muskoka Cottage Sanatorium was built in Ontario by a voluntary association, the National Sanitarium Association, which had been formed by citizens interested in Trudeau's work in the care of tuberculosis patients in the United States. Subsequently sanatoria were built under either provincial or voluntary auspices in the other provinces.

The latter part of the nineteenth century and the early years of the present century were periods of rapid population and economic growth for Canada. The extension of education on a public basis, the influx of immigrants from Europe, the rising material prosperity, the impact of religious concepts of responsibility for one's neighbours, the changing socio-economic views of society's leaders, the rapid growth of democratic political patterns, and the development of better forms of communication and transportation were some of the influences which combined with the revolution in man's knowledge of disease, its prevention, and control to alter completely the older pattern of health services.

THE MODERN PERIOD

Public Health

In the period after World War I, public health attention extended from the purely environmental aspects of community health control to include school health services and maternal and child health services. Stress was laid on education about measures for personal health and hygiene, as well as on the provision of special protection through immunization procedures. These developments led to the creation of a new public health worker, the public health nurse. Public health concern has extended to include such activities as screening programmes for the early detection of disease, endeavours to cope with newer environmental hazards in man's environment, both physical and social, for example, air pollution, irradiation hazards, and poor housing, and, in some areas, the provision of certain direct personal services, such as a visiting nursing service.

There has been a rapid development of public health services at all levels of government. General preventive measures for individuals and groups, group case-finding, health education and personal health supervision, and many regulatory activities are now carried out at the local community level. Larger municipalities developed full-time public health departments. However, in rural areas it was not economically possible to do so nor was it possible to obtain necessary staff. The idea of a health unit, formed by a combination of smaller municipalities was introduced to permit the maintenance of a full-time programme provided by full-time staff members. In 1921 a trial project was established in Saanich, British Columbia. In 1926 the first full-time health unit was established in Beauce County in Quebec. Since then full-time health units in rural areas and municipal departments in larger urban communities have been established in all provinces. The majority of the population is now served by full-time community public health workers.

The role of the provinces at the beginning was limited to general regulatory and supervisory functions and, therefore, full-time provincial health departments were not formed in the early years. All provinces now have well-established provincial departments responsible for public health matters. Their role grew to include the provision of financial assistance to local public health programmes, and extensive consultative and technical services, such as laboratories, maternal and child health, epidemiology, public health nursing, health education, vital statistics, nutrition, occupational health, environmental sanitation, and dental health. Finally, the development has led, in most provinces, to the direct provision by the province of local public health services through health units, except in the case of large cities. On the other hand, in Ontario, local autonomy in the provision of local services has continued.

No formal department in the Dominion Government was formed until 1919. The Dominion's public health activities were largely in matters such as maritime quarantine, the health of potential immigrants, environmental health services on federal projects and interprovincial carriers, food, drug, and narcotic control, national vital statistics, and direct health services for Indians, Eskimos, veterans, the armed forces, and sick mariners. In 1944 the Department of National Health and Welfare was formed. Activities have been extended to include the provision of substantial grants-in-aid to the provinces for various types of public health

services, for professional and technical training, and for research under the National Health Grants programme and, more recently, for hospital insurance and diagnostic services under the Hospital Insurance and Diagnostic Services Act of 1957. Extensive consultative and laboratory services are available to the provinces. Also the Dominion has developed services for general planning and research on health care programmes and in international health.

Medicine and Hospitals

The present century has seen changes in medical education as radical as those in public health under the impact of scientific developments and the efforts of men, such as Flexner and Osler. Scientific and clinical medicine has come to its full flowering and in turn has changed the whole pattern of providing organized health services in the community. Improved knowledge and skills require ever better facilities for their application. The paradox of the scientific and technological revolution is that it has diminished relatively the capacity of the individual doctor to meet man's health care needs at the same time as it has vastly increased the capacity of medicine as a whole to do so. As in so many other fields of science, the pressures of new knowledge have forced specialization of functions, a division of labour and the development of organized patterns for providing health care. Circumstances are turning the provision of health care into the work of an interdependent team with interdependent facilities. To give full and effective service to his patients, the family doctor of today has to make use of hospitals with their specialized staffing and facilities, of many kinds of specialists to whom he refers more complex cases, of important paramedical personnel, such as nurses, physiotherapists, social workers, and technicians, and of many community resources, such as public health service, visiting nursing services, home care services, mental health services, ambulance services, and rehabilitation services. This specialization of function is both necessary and inevitable but it has also created problems and is an important root of many of the issues which today are faced in the provision of health services.

Hospitals also have felt the impact of change. The once fearsome institution where one only went as a last resort has become a symbol of healing where one expects, if not always cure, at least some alleviation of suffering. For the doctor, the hospital has become a real centre of scientific medical work. This is especially true for the specialist. There has been a trend, in teaching hospitals and in large urban hospitals, to the appointment of specialists as staff doctors, in some few cases on a full-time, salaried basis. The trend in most urban hospitals is towards specialist department heads and to limitations on the hospital privileges of the general practitioner. There has also been an awareness of the need for some differentiation within the hospital pattern based on the seriousness of illness and on the degree of skilled care and special facilities required. This has closely paralleled the growth of specialization within medicine itself. Advances in scientific knowledge also have resulted in increases in the numbers of professional and technical paramedical staff members and in the need to purchase much expensive equipment. All of these developments have contributed to a steady rise in hospital costs.

The hospital changes just described have occurred chiefly in the large, growing urban centres which now contain well over one-half of the Canadian population. In smaller urban centres and rural areas on the other hand the small general hospital in the local community to which all doctors belong continues to

be the general pattern. Serious questions are being raised about the type of work which should be carried out and about the quality of care possible in such undifferentiated hospitals with limited professional, auxiliary, and technical personnel, limited facilities, and a scarcity of ready consultant service in emergency situations.

Until recently, activity by the provinces in the direct provision of hospital service was restricted to maintaining and financing care in mental hospitals and tuberculosis sanatoria. Then during the depression of the 1930's many municipalities found themselves unable to meet the costs of basic assistance, including hospitalization, for their indigent citizens. Provincial assistance to general hospitals and towards plans for financing basic medical care for specific indigent groups began and has steadily grown. This was carried forward by the need for more extensive care for people with certain types of disease, for example, poliomyelitis and cancer. Then provincial hospital insurance programmes were developed after World War II in several provinces.¹

Under the federal Hospital Insurance and Diagnostic Services Act of 1957 and complementary legislation in each province, the operating costs of hospitals are now covered through provincially operated plans.² A good deal of supervision and advice on planning and operating hospitals are provided by the divisions concerned with hospitals and the hospital plans either in provincial health departments or in separate provincial hospital commissions. As well, extensive federal and provincial grants for hospital construction, extension, and renovation are now made.

Rehabilitation

Since World War I extensive rehabilitation programmes have been developed for injured workmen, through provincial Workmen's Compensation Boards, and for the armed forces and veterans by the Dominion Government. Voluntary agencies have also played an important role in demonstrating the worth of rehabilitation for certain types of disease. However, rehabilitation services for the general public have been slower to develop until recently. Recognizing a need to use services and facilities to better advantage, a few communities have established voluntary rehabilitation councils.³ Many larger communities work through voluntary social planning and health and welfare councils, which have wider interests than just rehabilitation. These have given energetic and constructive leadership but they face problems arising from the special interests of groups and organizations and from an inability to co-ordinate activities except where a willingness to co-operate exists.

¹Newfoundland has had a medical and hospital care programme for the people in the outports since 1935 but joined Canada as a province only in 1948. Provincial hospital insurance plans were begun in 1947 in Saskatchewan, in 1949 in British Columbia, and jointly with individual municipalities in 1950 in Alberta. Manitoba began a plan in 1957 under which the Province paid standard ward costs after the first 180 days.

²The Dominion shares on the average 50 per cent of the agreed standard ward operating costs of hospitals, excluding mental and tuberculosis sanatoria, and any agreed out-patient services.

³For example, Ontario County and the City of Oshawa in Ontario have set up an Area Rehabilitation Council.

Organized Home Care

In several communities,¹ organized home care programmes have been demonstrating that sick people can be cared for outside the hospital and that others can be returned to their homes and activity more quickly. However, most places still have either only visiting nursing services² or no services at all. In a relatively few communities voluntary agencies provide some homemaking and physiotherapy services.

Care of the Aged

Closely related to home care is the care of older people. With the trend to urban living, there has been a change in housing patterns to apartments or to smaller houses. Many older people are no longer cared for in their own homes or by their own families. At the same time, more people are living longer. More homes for older people have been built. These homes, although originally designed to serve mainly people in lower income groups, are being used increasingly by people in higher income categories as well. There is a gradually increasing awareness of a need for a diversity of facilities in the community, such as low rental flats, organized home care services, and recreational facilities, to be provided under both official and voluntary auspices. Services for older people are in the developmental phase as yet in Canada and to date efforts at co-ordination have been fairly limited. In some communities older people themselves have formed Senior Citizens Councils, together with other interested people and agencies.

Mental Health

One of the most serious problems for many years has been that of mental illness. At a time when little was known about causation and treatment methods were limited, the large provincial mental hospitals provided chiefly custodial care. In recent years, developments in medical knowledge have resulted in many patients being returned to the community. In most provinces permanent and travelling mental health clinics providing certain diagnostic and follow-up services for some communities have been established, either through provincial mental hospitals, local health departments, or under voluntary auspices.

Voluntary Agencies

The growth of voluntary agencies of all types has been an important factor in the provision of health services. The particular services provided are affected by existing official health and welfare programmes since a voluntary programme often is begun to fill gaps, to stimulate new programmes, or to provide personal health needs which are not available under legislation. However, there are difficulties in co-ordination, of overlapping interests, and in adapting programmes to changing needs. Increasingly, problems are arising from the limitations imposed by financing through public philanthropy. Many voluntary agency services today depend heavily on public grants from different levels of government as well as on the generosity of the public for financial support.

¹Winnipeg, Quebec, Toronto, for example.

²Provided either by the Victorian Order of Nurses, a voluntary agency, or by local public health departments.

PART I

ORGANIZED COMMUNITY HEALTH SERVICES IN ONTARIO

LOCAL PUBLIC HEALTH SERVICES

ORGANIZATION, STAFFING AND GENERAL FUNCTIONS AND FINANCING

The General Pattern in Ontario

The Public Health Act of Ontario¹ requires every municipality to appoint a local board of health, except when two or more municipalities have agreed to form a health unit. Then a board of health for the entire area is appointed as laid down in the provincial Order in Council establishing the health unit. This health unit board replaces the formerly separate municipal boards of health.

The board of health of a municipality is appointed by the municipal council at its first meeting each year. The size and general composition of municipal boards of health are set down in the Act. They vary with the status and size of a municipality and room is left for local variation as to whether a majority of the members are municipal councillors or are non-elected but interested ratepayers. The chief elected member of council² and the local medical officer of health are members of the municipal board of health. The municipal clerk usually serves as the board's secretary, except in large municipalities where a separate secretary is appointed as a rule.

The board of health of a health unit is constituted according to the terms of the specific provincial Order in Council which established the unit. One member is appointed by the Lieutenant-Governor in Council.³ The procedure for appointing the other members varies with the nature of the health unit area. For example, if an entire county has formed a health unit then these members would be appointed by the county council, which contains representatives of the locally elected, municipal councils. In cases where either two or only a few local municipalities have formed a health unit, the constituent, locally elected councils would appoint representatives, in general, proportionate to their populations. The provincial representative is appointed for a term of three years, which is renewable at the pleasure of the Crown,⁴ whereas the other members are appointed annually by the appropriate council or councils. The medical officer of health for a health unit is rarely a member of the board of health. The county

¹Revised Statutes of Ontario, 1961. Unless otherwise noted, any requirements mentioned in this section of the study refer to the Act and regulations made under it.

²Mayor or reeve.

³In practice, by Order in Council.

⁴In practice, the Ontario Government.

clerk-treasurer is usually the secretary of a county health unit board. Where a health unit does not cover a full county then the secretary usually is the clerk of one of the constituent municipalities. He may, however, be someone other than the county clerk or a municipal clerk.

The duties of a board of health are, in general, to oversee and ensure the carrying out of the requirements of the Public Health Act, regulations made under the Act, and any county or local municipal by-laws on public health. Local boards of health are almost wholly autonomous in Ontario. The Ontario Department of Health has certain general supervisory powers but its chief functions in relation to local public health services are to stimulate activities, to offer special consultative and other services, to administer applications from local boards for grants under the National Health Grants programme,¹ to relay the funds so obtained, and in the case of health units only, to pay a general grant towards operating costs.² Local boards of both municipalities and health units prepare their own budgets for submission to the council or councils concerned for approval. A budget may be amended before being passed. The council or councils provide the accepted budget revenues from local tax funds.³

Every local municipal council and, in the case of a health unit area, every health unit board of health is required to appoint a legally qualified medical practitioner to act as medical officer of health. In most large municipalities, such as cities and other heavily populated municipalities, and in all health units, he is employed on a full-time basis and must have special qualifications in public health.⁴ In smaller municipalities the medical officer of health may be appointed on a part-time basis and need not possess special qualifications in public health. He is appointed and paid by the local board but cannot be dismissed without the permission of the provincial Minister of Health.

Other basic staff members include public health nurses,⁵ sanitary inspectors,⁶ and secretarial and clerical staff. They are employed on a full-time basis in larger municipal health departments and in health units but in smaller municipal departments may serve on a part-time basis only, if they are retained at all. In a small rural municipality, a part-time medical officer of health may serve alone and use the municipality's clerical services as required.

Other staff members employed on either a full-time or part-time basis by some municipal health departments and health units include dental public health

¹Offered by the Dominion Government to the provinces for general public health, training, public health research, hospital construction, laboratory and X-ray services. Some are outright grants and some are matching grants.

²No general provincial grants are made to municipal boards of health though small grants for specific purposes, for example, a venereal diseases treatment clinic, may be made on occasion. The board of health of a health unit receives a percentage grant which varies from 50 per cent of the baseline service budget for rural health units down to approximately 25 per cent for semi-urban health units.

³Local funds are obtained from a property tax.

⁴A Diploma in Public Health or its equivalent from a University School of Hygiene or Public Health. Some have the additional qualification of a certificated specialist in public health of the Royal College of Physicians and Surgeons of Canada but this is not required.

⁵Public Health nurses must have a Diploma in Public Health Nursing or its equivalent from a University School of Nursing.

⁶Sanitary inspectors in full-time positions must hold the Certificate in Sanitary Inspection (Canada) from the Canadian Public Health Association. Their title is to be changed officially in 1964 to public health inspector and the qualification to the Certificate in Public Health Inspection (Canada).

officers,¹ veterinary public health officers,² health educators,³ medical social workers,⁴ registered nurses,⁵ and registered nursing assistants.⁶ Most programmes also obtain the part-time services of local physicians and dentists on a fee arrangement to assist in clinic and sometimes school programmes. In a few large municipalities, the services of specialists in fields such as paediatrics and psychiatry may be obtained on a part-time sessional basis or, in certain instances, on a full-time salaried basis. Though these additional staff members may be employed by a board of health from its own funds alone, almost always their employment depends upon the obtaining of National Health Grant assistance.

Discussion of Field Study Findings⁷

Organization

Huron County has a health unit providing full-time services for the 53,805⁸ people in the county. The City of Peterborough has a municipal health department which provides full-time services for the approximately 47,185⁹ people in the city. In the District of Timiskaming, full-time services are provided by the Timiskaming Health Unit for 48,207¹⁰ of the 50,971¹¹ people in the district. The municipalities which chose to remain outside the unit have appointed local practising physicians as part-time medical officers of health. Metropolitan Toronto is composed of 13 municipalities with an estimated 1,621,849 people.¹² Seven of the municipalities have full-time health departments, including a health unit serving two of the municipalities,¹³ which serve a total estimated population of 1,536,320 people.¹⁴ The other six municipalities, with an estimated total population of 82,467 people,¹⁵ have part-time medical officers of health.

There is a local board of health for each of the municipal health departments and health units studied. As might be expected from the description of the composition of local boards of health in the previous section of this chapter,¹⁶

¹The qualification of a Diploma in Dental Public Health or its equivalent from a University School of Hygiene or Public Health is preferred but not required.

²The qualification of a Diploma in Veterinary Public Health or its equivalent from a University School of Hygiene or Public Health is preferred but not required.

³The qualification of a Certificate in Public Health (Health Education) or an equivalent special qualification from a University School of Hygiene or Public Health is preferred but not required.

⁴Either a University Bachelor's or Master's Degree in Social Work or other acceptable qualification in social work is preferred but not required.

⁵Registered as a nurse under The Nurses Act, 1961-62 (Ontario), after education in an approved university or hospital or independent School of Nursing and an examination.

⁶Until recently, in Ontario they were known as certified nursing assistants. Under The Nurses Act, 1961-62 (Ontario), they are known as registered nursing assistants. They must have trained in an approved school and have passed the required examination.

⁷For specific details, reference should be made to Appendixes I-IV.

⁸Dominion Bureau of Statistics 1961 census data.

⁹Dominion Bureau of Statistics 1961 census data. An annexation, effective as of January 1, 1963, raised the population to just over 50,000 people.

¹⁰As estimated in the 1961 Annual Report for the Timiskaming Health Unit Board of Health.

¹¹Dominion Bureau of Statistics 1961 census data.

¹²Dominion Bureau of Statistics 1961 census data.

¹³Township of East York and Town of Leaside.

¹⁴Dominion Bureau of Statistics 1961 census data for the combined populations of the City of Toronto, Township of Etobicoke, Township of Scarborough, Township of York, Township of North York, Township of East York, and Town of Leaside.

¹⁵Dominion Bureau of Statistics 1961 census data for the combined populations of the Town of Mimico, Town of New Toronto, Town of Weston, Village of Forest Hill, Village of Long Branch, and Village of Swansea.

¹⁶See p. 11.

the boards show considerable variation as to the proportions of members who are municipal councillors and who are non-elected but interested ratepayers.

The effectiveness of a board depends largely upon the continuity of membership and objectivity of its members. Some municipal council representation is desirable since this permits liaison in planning and financial matters. On the other hand, a board composed of a majority of elected municipal councillors may lack continuity in membership and a primary concern with health matters. Boards with a majority of interested citizens who have no direct municipal political interests appear to be more effective in studying objectively proposals brought to them on health matters.¹ Size also may be a factor. One of the health unit boards has some 20 members because each municipality wishes to be represented. Such a board may prove unwieldy.

The medical officer of health is rarely a member of the board in a health unit, whereas in municipal departments he is. It would seem that the former arrangement is better since it is difficult to be a voting member of a policy-making body for which one is also the chief administrative officer. His position should be that of a technical expert, a sort of executive-secretary. He would still attend meetings of the board but always in a non-voting capacity.

The municipal clerk or a member of his staff is usually the secretary of a local board of health. He is supposed to bring liaison between board and municipality administration and financing but he is also supposed to be the servant of the board. Especially in smaller communities and in rural county health unit areas, the municipal clerk may gain considerable *de facto* policy-making power, partly because he is the only person with continuity of office who knows the details of municipal functioning.² In our view the secretary of a board of health should have his role more clearly defined, so that he is in fact as well as in name the servant of the board.

It is also our opinion that modifications in the pattern of local public health organizations in Ontario are necessary if the organizational problems created by almost total local autonomy are to be reduced. We believe these can be achieved without destroying worth-while local participation in establishing policy and in administration. It is suggested that a regional health services organization as outlined in Chapter IV would be a suitable pattern.³

Staffing and General Functions

Ratios of full-time staff equivalents to population vary in the communities studied from approximately 1:1,300-2,000 in full-time departments to 1:5,000 in part-time urban departments. In the part-time rural programmes the population served is so small as to make it uneconomic to have separate staff, other than a part-time health officer. Yet, their needs are no different from comparable areas with a full-time programme and staff. It is our firm view that part-time public health services have been inadequate for some time but that more than

¹A wider selection of interested and competent potential members is possible since people in some occupations may be reluctant to run for public office or are not permitted by their terms of employment to do so. For example, banks do not usually permit their officers to stand for election. Certain restrictions are also placed on provincial and federal civil servants.

²See Appendix II, p. 222.

³See pp. 69-73.

exhortation and persuasion will be needed if service units of effective size with full-time staffs and modern programmes are to become available in areas now without full-time services. This is a provincial legislative responsibility.

At the present time, there are shortages of medical officers of health. This is partially related to incomes which tend to be lower, except in large departments, than in many other medical fields but also, we believe, to the relative isolation of the public health worker from other professional colleagues. This last situation arises from several factors, such as the type of the work being done at present in most areas by health departments, misunderstandings between health officers and doctors in private practice, and to feelings by many doctors that physicians in public health are the misfits and less competent members of the medical profession. In more recent years in some places they have become convenient scapegoats for the aroused fears of some sections of the medical profession over the changing patterns in medical practice and the increasing role of governments in the provision of health services. These attitudes are readily communicated to medical students and to doctors who might otherwise consider a public health career. In turn they affect some practising health officers who may make little effort to develop close relations with their practising colleagues.

During the field studies it was clear that the proportion of competent and high principled medical officers of health is little different from those in other fields of medicine. Many have warm and close relations with their colleagues in clinical fields. It is our view that some of the problems could be alleviated by integrating the health department programme more closely with the work of the hospitals and other community health services and with the work of the physicians in clinical practice, as suggested later in this chapter¹ and in Chapter IV.²

The dramatic success of public health in largely achieving so many of its original objectives has created a partial vacuum in objectives. The work of the health officer needs to regain the challenge and satisfaction which it held when the battle against the communicable diseases and against the basic environmental health problems was at its peak. New problems for public health exist and many are presented throughout this study. But legislation, administrative structure, and to some extent training,³ have not altered sufficiently to permit the new problems to be tackled as effectively as possible.

It is our opinion that the health officer's functions should be first of all those of a medical administrator who is equipped to plan, to administer and co-ordinate, and to evaluate services. In the second place, he should be the local consultant and expert in epidemiology and community health research, not only in communicable diseases but also for newer problems of the public's health, such as cancer, heart disease, and the chronic diseases in general. He should be involved in the provision of adequate community services, in home care, the care of the aged, accident control, rehabilitation, mental health, and family planning,

¹See pp. 25-26

²See pp. 69-73.

³Since this was first written, the School of Hygiene in the University of Toronto has completely revised its diploma courses to give much greater emphasis to administrative theory and practice, including planning and evaluation of services, and to epidemiological and statistical methods. As well graduate degree work is available in these fields.

to mention some of the more important community-wide health problems now being faced. Personal health care should, as far as possible, be carried out by physicians in clinical practice with the assistance of health department staff, especially public health nurses, as suggested elsewhere.¹ Consideration should, however, be given to the fact that certain personal preventive services, such as immunization and multiphasic screening, may be more effectively provided on an organized community basis. Finally, salaries have to be on a more satisfactory basis than the whim of local boards and councils.

In summary, an altered administrative structure, some realignment of responsibilities, a revision in training to give greater emphasis to administration, to epidemiology, and to statistical research methods, and a more equitable income pattern are needed, if an adequate supply of competent recruits is to be assured.

There is one other fundamental problem, as we have seen it through our educational responsibilities in the undergraduate and graduate fields and as so many of those interviewed on the field studies have expressed it. Most Canadian medical schools provide their students with a wide basic science preparation for clinical and technological medical work but they provide little or no useful preparation in sociology, psychology, statistics, and economics, which are basic sciences for organized community health work. To a large extent, unlike teaching in clinical medicine, teaching in public health and social medicine and also in psychiatry, rehabilitation medicine, and geriatric medicine is handicapped because the students do not have a satisfactory basic social science understanding. It is not surprising that many such graduates have only limited awareness of the social aspects and community responsibilities of medicine.

Public health nurses are more readily available and we have been impressed by the uniformly high calibre of people in this work. However, shortages exist, especially in rural areas, and turn-over is high. As in other nursing fields, relatively low incomes as compared with other professions remain a depressing factor to recruitment and to holding staff. On the other hand, a public health nurse has a large measure of independence and scope for personal judgement in her work with the families she sees. One important problem in staffing is that the work tends to be restricted to prevention, teaching, and demonstration and includes little or no bedside care. In a number of rural and smaller urban communities where there are no visiting nurses a limited bedside service is being provided.

It is clear that a combined programme and a closer tie-in with the practising physicians would greatly enhance job satisfaction for the nursing group. At present because of a limited use of auxiliary nursing and secretarial staff in all but some large departments, much time is spent on unskilled and routine tasks. Greater attention to the use of auxiliary personnel is needed. In most areas studied, the use of married staff and part-time nurses has proven invaluable. Further attention to the use of this reservoir of nursing personnel is indicated, especially on various part-time arrangements.

In the case of sanitary inspectors, questions of training, status, and function are uppermost. It is difficult to assess the part which income levels play in recruitment for this work, since at present in Ontario they are relatively higher

¹See pp. 25-26.

than for other fields requiring comparable academic qualifications. Most of those interviewed felt that income levels were not a major problem at present but that the difficulties which some departments and units face in obtaining sufficient sanitary inspectors are more related to questions of status and job satisfaction and to the greater attraction for many young people of living in cities as opposed to smaller communities. Certainly several of the communities visited were short of sanitary inspectors and were sponsoring trainees in an effort to meet their requirements. Training in Canada is obtained through a correspondence course provided by the Canadian Public Health Association¹ or through approved courses at the University of Montreal School of Hygiene and at the Ryerson Polytechnical Institute in Toronto.^{2,3} Whatever the method of training, all sanitary inspectors must meet the requirements of the Board of Certification of the Canadian Public Health Association for the Certificate of Sanitary Inspection (Canada). In Ontario, a valuable innovation has been the establishment of the course by the Department of Health which uses the facilities of the Ryerson Polytechnical Institute in Toronto. As of September 1963, the course will be under the jurisdiction of the Ryerson Institute with assistance in teaching from the staff of the Department. This idea could well be extended as other large technological institutes are established in Ontario and in other provinces. It will permit better standards of selection and teaching and provide the status which the sanitary inspectors feel is lacking at present.

A further problem relates to the precise functions which a sanitary inspector is to perform. If his job is solely one of the inspection of premises and facilities to determine whether they meet straightforward requirements, then less training and less rigorous academic qualifications are needed than if his job requires judgements on more complex matters, such as the installation of water systems, sewage systems, and dairy equipment and includes educational responsibilities. The question of the functions to be performed by a sanitary inspector has yet to be clarified completely, though the trend is towards the more skilled type of role.

Other personnel, such as veterinary public health officers, dental public health officers, health educators, medical social workers, psychiatrists, etc., may be staff members in some departments, especially in large centres. Several factors deter their more extensive use. In Ontario, there is reluctance, for financial reasons, on the part of many local municipalities to employ directly more than the basic types of staff. In general, special staff members are partly

¹This course of nine months uses a prepared manual and requires the Candidate to complete weekly exercises which are marked by an examiner. Candidates must also provide proof of at least three months of field experience under supervision either by a certificated sanitary inspector or a full-time medical officer of health. The course is open to applicants from all provinces except Ontario and Quebec where formal intramural courses are required, from the Territories, from the armed forces, and from the Dominion Government service. On completion of the course the Candidate sits for the written examinations, undergoes an oral examination by a panel of at least three members (one of whom is a physician, veterinarian or public health engineer, and one of whom is a sanitary inspector), and completes a field inspection of at least two environmental sanitation problems on which he must submit a written report. A successful Candidate is awarded the Certificate of Sanitary Inspection (Canada).

²Graduates are given a certificate of graduation. They are exempted from additional written examinations but must still undergo an oral examination and report of field inspections set by the Canadian Public Health Association.

³Candidates with acceptable foreign certificates (United Kingdom and U.S.A. usually) are required to spend one year of employment in an approved local health department or unit. On completion they are required to sit for the Certificate of Sanitary Inspection (Canada) examinations in the same manner as correspondence course candidates.

paid through National Health Grant funds. A local board may not continue employment if the grant terminates. The resultant uncertainties of tenure and income level defer both recruitment and retention of such personnel. Often too the size of population presently served by a number of the health departments and units is insufficient to warrant the employment of special staff on a full-time basis, even though their services would be useful. Some type of larger, regional administrative pattern would appear to provide a more valid base for the use of these personnel. Moreover, the skills of some types of specialists could in many cases be useful to other organized community health services than the public health programmes alone.

Financing

In the areas studied annual *per capita* expenditures on local public health department or unit services varied from approximately 50 cents to \$4.10 in 1961 or in 1962. Budgets in rural municipalities with part-time health officers may cover little more than the honorarium paid these physicians.¹ Even for the part-time urban programmes in Metropolitan Toronto total budgets were generally below \$10,000 per year and most of the money was for barely minimal services through largely part-time staffs. Thus, in fact, the differences in terms of staffing and services were much greater than the *per capita* expenditures and total budgets might suggest.²

At present rural health units in Ontario receive grants of up to 50 per cent of their budgets from the Province. Semi-urban units receive lesser percentages down to approximately 25 per cent. However, municipal health departments as opposed to health units receive provincial financial assistance only indirectly through the distribution of National Health Grant funds. No general provincial grants are made available and only occasionally are small grants for specific purposes made. Of the municipal departments visited, the most received in 1961 from provincial allocation of federal funds was 10 per cent of the budget³ in one case. On the other hand one large municipal department visited received less than one per cent of its budget from this source.⁴ This occurs because the National Health Grants to the provinces for local public health programmes are almost entirely for staff over the base-line requirements and for new programmes or extensions in existing ones over basic levels of service.

It is clear that in Ontario many local municipalities find difficulty in providing basic public health staff and services from their existing revenue sources and even large ones have difficulty in financing extensions and new services. Only when it is willing to pay and can pay for the basic services by itself can a municipal board of health become eligible for much grant assistance.

Competent staff cannot be obtained and adequate statutory services provided on the budgets available in some of the municipalities studied. Small populations cannot support a satisfactory modern local public health service on the basis of municipal tax sources alone.

¹In one region visited the honoraria were as low as \$25.00 per year and no more than \$250.00.

²Reference for detailed data should be made to Appendixes I-IV, pp. 173-317.

³\$24,467.00 in a total budget of \$224,610.00. See Appendix IV, p. 306.

⁴\$2,000.00 in a total budget of \$356,893.00. See Appendix IV, p. 306.

If a satisfactory province-wide level of services is to be provided, the existing pattern of provincial support for local health services should be reviewed so that programmes of either the health unit or municipal health department type may obtain a fair share of available provincial assistance. A satisfactory level of support is not easy to determine. One's view tends to depend upon whether one favours provincially administered and financed local public health services, as seen in most other provinces, or whether one favours a large measure of local or regional responsibility for administration and financing. We believe that the administrative suggestions in Chapter IV¹ take into account the worth of both approaches. In general, it is our opinion that a regional pattern of health services would be more economic in terms of staff use and programme costs than many of the existing small areas served by separate departments. However, the regions should be planned so that the areas and populations served are sufficiently small to retain a sense of local interest in both financing and planning. It is also our view that in a province, such as Ontario, with its strong traditions of local autonomy that the sharing arrangement for costs should be in the approximate range of 70 per cent by the province and 30 per cent by the local area for predominantly rural-small town regions, and 60 per cent by the province and 40 per cent by the local area in predominantly urban regions. These levels would be in keeping with the actual tax revenue available to the two levels of government.

It is furthermore our view that basic salary levels and common pension arrangements for the various types of health worker should be set by the province. The cost should be included as a specific part of the provincial grant to a regional health services board. This would guarantee a basic provincial standard of income in the public health field but would still permit additional salary payments and increments to be paid by regional boards as a means for attracting staff. The staff, in turn, would have greater freedom to change positions than is now possible when separate pension arrangements exist.

PROGRAMMES²

Under the Public Health Act and its regulations certain basic communicable disease control and environmental sanitation services are mandatory for all local boards of health. Other services, though regarded as part of a modern public health programme, are permissive. A striking difference between the full-time department and the part-time department is the extent of services. In the full-time department the statutory programmes of communicable disease control, environmental sanitation, and an arrangement with the school boards to provide a mutually agreed service, are well established, though varying in detail to some extent. On the other hand, the part-time departments with little or no full-time staff have programmes limited in some instances to the barest interpretation of the statutory requirements. When it comes to other services, regarded as basic to a modern programme, such as home visiting, maternal and child health services, and to an extension of services to meet newer problems of the public health, many of the part-time departments have virtually no programme.

¹See pp. 69-73.

²For specific programme details in the four communities studied, reference should be made to Appendixes I-IV, pp. 173-317.

In our view, part-time services have not been a satisfactory procedure for some years and their inadequacy becomes more as each year goes by. Yet, as now organized, many municipalities have neither the population nor resources to support a full-time modern programme. A regional pattern of health services organization would provide a suitable solution.¹

Some comments may be made about the specific basic programmes in the full-time departments. These programmes were established and have grown up in response to specific needs. In many cases, the character of the need has now changed partly because of success in combating many of the communicable diseases, partly because of the engineering and technological developments in fields, such as water and sewage control, and partly because of socio-economic changes in Canadian society, for example, the growth of prepayment sickness insurance plans and their effect on personal clinical services provided by health departments. Though some adaptation to these changing circumstances has occurred, it is our view that further careful study of desirable alterations in programme emphasis is required.

Communicable Disease Control

General

The Public Health Act and regulations outline the responsibilities of local boards of health and medical officers of health for reporting, implementing isolation and quarantine procedures, disinfection of dwellings, and other matters of communicable disease control.

It is known that the common childhood diseases are only partially reported because physicians often see little reason for doing so. On the other hand, the reporting of serious communicable diseases with community implications, such as diphtheria, tuberculosis, venereal diseases, smallpox, and infectious hepatitis, is most important. In our view, routine reporting by physicians should be restricted to the serious communicable diseases. Where information on the extent of other communicable diseases or on the level of immunity in a community is desired, regular inquiries and serological studies on a sampling basis could be used. Greater attention to reporting and epidemiological studies on newer problems of the public health, such as cardiac disease, cancer, disabling conditions, and accidents, should be considered.

Active immunization against common infectious diseases is provided by local health departments through the maternal and child health programmes, school service, and through specific clinics and mass campaigns. Although personal preventive care should in general be provided by personal family physicians, consideration should be given to the fact that certain personal preventive services, such as immunization, may be more effectively provided on an organized community basis.

Tuberculosis Control

The local health department or unit either facilitates or directly provides individual and group examination procedures, including tuberculin tests and chest films. Reporting of cases and contacts, maintaining a case register, and

¹See Chapter IV, pp. 69-73.

notifying other municipalities about patients who change their place of residence are required. Arranging for contact examinations and the supervising of patients either on home care or on post-sanatorium therapy are other activities of the local health department or unit. Treatment in sanatoria or general hospitals, conveniently located throughout the province, is covered under the Ontario Hospital Insurance Plan.¹

The tuberculosis control programme was found to be one of the most satisfying programmes for the staff of local health departments. There is close liaison with doctors in private practice, hospitals, sanatoria, and the local voluntary tuberculosis associations.

Venereal Disease Control

Under the Venereal Diseases Prevention Act,² the physicians report cases and contacts direct to the provincial Department of Health. The local health authorities are concerned with locating and arranging for the examination of reported contacts. They also locate persons reported to have defaulted in treatment and arrange for a return to treatment. Clinics are available in some of the larger municipalities. As well there is provision for the payment of private physicians for treating people who cannot afford care otherwise. The antibiotics used in treatment are provided free by the Ontario Department of Health.

In general, reporting of contacts is less than satisfactory and there is evidence to suggest that even cases are not fully reported. The prevalence of these diseases is such that they continue to be problems of public health concern. More intensive education of physicians on the importance of reporting cases and of obtaining contact information is suggested.

Sanitation

The responsibilities of the local authorities for environmental sanitation are outlined in the Public Health Act.³ The over-all supervision of public water supplies, public sewage systems, plumbing regulations, and lake and stream pollution control is a responsibility at the provincial level of the Ontario Water Resources Commission. Municipal systems are operated by departments other than public health. However, the health department conducts routine tests to assure that no health hazards exist. On the other hand, local health departments retain statutory responsibilities for the supervision of private water and sewage systems.

Food-handling establishments, such as dairies, restaurants, food shops, slaughter houses, frosted food locker plants, bakeries, etc., are subject to local health department inspection. Rodent and insect control measures are conducted locally. The investigation of alleged public health nuisances is also a local health department responsibility. Other health department responsibilities in the environmental control field may be established in any area by local by-laws on such matters as facilities to be inspected, and air pollution control measures.

¹See also Chapter II, pp. 33, 34.
²Revised Statutes of Ontario, 1961.
³Revised Statutes of Ontario, 1961.

One of the needs is for revision of existing legislation,¹ so that standards and requirements may be kept in line with modern practice² and so that provisions may be made for newer environmental hazards, such as air pollution, radiation, and for problems presented by food vending machines, automatic laundry and dry cleaning establishments and private swimming pools. Also, the existing legislation is general in many respects and results in different interpretations and degrees of enforcement, often in adjoining areas. There should be common and more precise province-wide standards. Finally, it is our opinion that in so complex a field, revision should be a continuous activity.

There are still too many communities, not all rural or northern by any means, where the basic environmental services are inadequately met at present. These conditions should be corrected as quickly as possible because their continuing existence provides a hazard to the public health, quite aside from any economic and aesthetic aspects.

Though basic environmental control programmes, such as water, sewage, garbage, milk, and meat control, in their technical aspects are now largely the responsibility of other than health authorities, the health supervision and control aspects remain and should remain a health responsibility.

Maternal and Child Health

General

These public health services are permissive but all full-time and some part-time departments provide them to some degree.

Prenatal supervision is provided by attending physicians and by prenatal clinics at some of the large, city, general hospitals. Visits to the homes of pregnant women, of whom the department has heard, are made by the public health nurses on request or as considered necessary. Where they are active the visiting nursing organizations,³ the Victorian Order of Nurses and the St. Elizabeth Visiting Nurses Association, also provide prenatal visits on a co-operative basis with the local health department. Prenatal classes are conducted by the health department and unit public health nurses in many areas, in co-operation with the attending physicians and, where they exist, the visiting nursing associations. Fathers may be invited to certain of the classes. Practically all confinements in Ontario, except in very remote areas, now take place in hospitals.

In many communities, departments providing maternal and child health services try to arrange a public health nursing visit to any new mother while she is still in the hospital.⁴ If this is not possible a home visit is made as soon as

¹It is understood that legislative revisions are under way in Ontario.

²For example, in food and milk standards as they affect health.

³They only visit pregnant women at the request of a physician.

⁴This is done with the permission of the attending physician only.

possible after birth information has been received or obtained.¹ The effort is to visit initially within a week after the mother and baby have returned home and to offer further visits for educational purposes as desired and needed. A few departments have a policy of making a routine second visit during the first year of life.

Well-baby and child health conferences² or clinics³ are provided by all full-time public health units and departments and by many part-time ones. At these centres, instruction and demonstrations to mothers on the normal care and development of healthy infants and young children are provided. If illness is found, the mother is referred to the family physician or to a hospital out-patient department for specific diagnosis and treatment. At the clinics, where a physician is present, he carries out routine physical examinations and immunization procedures only. Mothers are again referred for any treatment indicated. Most areas, which hold conferences only, have a physician present at set times to give immunizations to the infants and pre-school children brought for this purpose.

A variety of useful books⁴ and other literature on aspects of maternal, infant, and child care are made available to people. In larger cities, a good deal of useful material is available in some languages other than English and French. This is desirable especially in larger urban communities where there are many recent immigrants who speak and understand little or no English or French. They are a difficult group to reach with all types of public health service, particularly personal ones, such as maternal and child health services.

Discussion of Field Study Findings⁵

The programmes in the areas visited varied in detail and extent though the general pattern was similar. Prenatal courses for expectant mothers and, on occasion, fathers were offered in all of the communities studied, either through the health department alone or under combined sponsorship with visiting nursing groups and voluntary social welfare councils. Though originally designed to instruct those in lower socio-economic groups, it has been found that most who attend come from the wealthier and better educated groups, often on the advice of their obstetrician or family doctor.

In one of the study areas most of the doctors send the names of many of their pregnant mothers to the health unit.⁶ At the doctors' requests these mothers are visited regularly between medical visits.⁷ Since most people in rural and

¹In Ontario birth notifications under the Vital Statistics Act are not sent to the local health departments. Where routine maternity visiting in hospitals is not carried out, it is necessary for department staff to visit the local registrar regularly or to make an arrangement with area hospitals. Problems arise in learning about babies born outside a particular health department or unit area. For example, in Metropolitan Toronto the parents may live in one municipality but confinement takes place in a hospital in another municipality.

²Public health nurses only are present.

³A physician is also present. This is a local practising doctor retained on an agreed basis for this purpose or the medical officer of health. In teaching centres, paediatric interns may provide service.

⁴Prepared by the Department of National Health and Welfare, the Ontario Department of Health, and a few large municipal health departments.

⁵For specific programme details in the communities studied, reference should be made to Appendixes I-IV, pp. 173-317.

⁶See Appendix III, p. 272.

⁷In part of the area, the Victorian Order of Nurses has a programme. The prenatal work and home visits for six weeks after delivery is shared in by the V.O.N. Thus, approximately 45 per cent of mothers were indicated as having received one or more prenatal visits in 1962.

smaller urban communities have a family doctor for emergency care at least, this arrangement with the unit means that few mothers go without prenatal supervision. In this same area, the public health nurses, by agreement with almost all doctors, visit the mother following delivery in the hospitals and subsequently, as indicated and on request, in their homes to assist them in caring for their infants. At this time, the nurses try to get the mothers to go to their doctors for a post-natal check-up. This effort is not well received by some doctors who may not routinely carry out extensive post-natal examinations. In general, however, the programme is well accepted and supported by all but a few doctors and families. The health unit also provides regular well-baby and child health conferences in the larger urban centres. Most doctors urge their mothers and infants to attend, including in some instances their own wives and babies. Primary immunization is offered at intervals by the medical officer of health at the conferences for those desiring it. A number of doctors were reported to prefer having the infants under their care immunized in this way.

In other communities studied, prenatal visits are made to any mother the department learns about.¹ Thereafter, further visits are made as indicated, especially to mothers known to have no family doctor or attending out-patient clinics, and when a doctor specifically requests visits. Though a small proportion of mothers receive their first care, either medical or nursing, when they arrive at the hospital in labour, no precise data were obtained.

In most communities outside large cities the public health nurses also visit mothers routinely in hospital, unless specifically requested not to do so. In these areas the approval of the local doctors was obtained when the procedure was begun. In the large urban communities, on the other hand, except for the group seen prenatally, the first knowledge of mothers with new babies may be received by a health department through its arrangements with the local registrar to learn of birth notifications. Delays in getting information may mean initial home visits²

¹A study in Ontario in 1958 indicated that the proportion of pregnant women visited was only about 13 per cent on the average of pregnant mothers in 46 out of 47 official health agencies which provided prenatal services, though in a few cases over 30 per cent of eligible mothers were visited. An estimated 76 per cent of the population of the province lived in the areas studied. Errors inherent in this method of calculation are described. G. K. Martin and K. B. Ladd, "Maternal and Child Health Services, Ontario, 1953", *Canadian Journal of Public Health*, March 1961, p. 112.

In our field studies using the same basis of calculation, the 1962 percentages (including V.O.N. where they exist) in communities with full-time health departments and units ranged from approximately 28 per cent in the East York—Leaside Health Unit area, approximately 12 per cent in Peterborough, 28 per cent in Huron County (there is no V.O.N. service), and 45 per cent in the District of Timiskaming Unit area (V.O.N. service in Teck Township only). The areas outside the Timiskaming Unit have no public health nursing or Victorian Order of Nurses services.

²*Ibid.*, p. 114; Martin and Ladd indicate that of the 46 official agencies in their survey with a birth registration visit policy, 34 (73.9 per cent) visited 75 per cent or more of eligible cases, 7 (15.2 per cent) visited between 50-74 per cent of eligible cases, and 5 (10.9 per cent) visited between 25-49 per cent of eligible cases (received at least one visit within the first four weeks of age). None visited a smaller proportion. These data do not include visits by the visiting nursing associations, such as the Victorian Order of Nurses. The percentages are based on comparing cases visited with live births.

In our study communities using the same calculation method, 1962 birth registration visits under 4 months of age by the official health agency public health nurses were approximately 71 per cent in the East York-Leaside Health Unit area (V.O.N. figures show 205 infants visited by 6 weeks of age. Therefore, something less than 11 per cent more are visited by 4 weeks.), 67 per cent of eligible cases in Peterborough (including V.O.N.), and approximately 64 per cent in the Timiskaming Unit area (approximately 70 per cent including the V.O.N. in Teck Township). Areas outside the latter unit in the Timiskaming District had no visiting service. Approximately 54 per cent of eligible cases in Huron County were visited under 2 weeks of age. No data for under 4 weeks are available. The percentage would be greater, of course. It was about 58 per cent in 1961.

In communities with routine newborn visiting programmes almost all babies are visited at least once by one year of age. It should be noted that visits in hospital are made to almost all mothers in the Timiskaming and Huron Health Unit areas, and that home visits are made only as indicated.

are not made for ten days to two weeks after the mother has returned home. It is suggested that a copy of the notification be sent routinely by the local registrars to the health department in the community of current residence of the mother. Also where the nurses are not permitted to visit patients in hospital, a proportion of time is wasted in unnecessary routine visits. A further problem occurs where visiting nursing groups, such as the Victorian Order of Nurses and St. Elizabeth Visiting Nurses Association, also have programmes of prenatal and newborn visiting. In spite of efforts to prevent duplication, dual visits do occur not infrequently.

The well-baby conferences are reported to be attended chiefly by people in lower socio-economic groups, but the tendency in quite a few places is for mothers in higher socio-economic groups to attend, not uncommonly on the suggestion of their own doctors. Especially in large cities, a proportion¹ of the lower socio-economic group neither use the facilities nor take their infants routinely to physicians. Efforts through public health nursing visits are made to get them to do so.

In some of the large urban centres, well-baby and child health clinics are held, with a physician present to examine children referred by the nurses and to give immunizations. He may be the medical officer of health but, in the City of Toronto, paediatricians and family doctors are employed on an hourly basis for this purpose. No treatment is given. Those requiring it are referred to their own doctors or to hospitals.

The extent of use of well-baby and child health conferences and clinics varies from community to community but has declined in many places in recent years, except where specially encouraged by doctors as in Timiskaming.² It is also found that the attendance of children over 12-18 months of age is negligible, except for immunization booster doses. This is considered to be a reflection of the generally good economic level in Ontario and to the large enrolment in various prepayment plans, some of which provide specifically for a number of well-baby visits.

The benefits of proper, routine prenatal, post-natal, and well-baby care are now generally accepted. The problems, as seen during the visits, appear to be either in relationships among doctors, hospitals and health departments or economic in nature for people without prepayment insurance. In all groups a proportion of people and doctors seem little interested in this type of preventive care.

One suggestion is that, where group practices have been established, the health department could second public health nurses on a scheduled basis to assist them in carrying out their prenatal, post-natal and well-baby care, including primary immunizations, and home visits as indicated. This suggestion would not be practical for doctors in solo practice. Instead, it is suggested that such doctors be invited to use the facilities of the health centre buildings and nursing staff on a scheduled basis for providing such care to their patients. Such

¹No precise data were obtained.

²Comments are based on observations by health department and unit personnel.

arrangements would encourage supervision for all mothers and children. Frictions between practising doctors and the local health department would be reduced, since all personal care would be turned to the practising physicians who, in addition, would have the assistance of public health nurses in providing it. The proposal assumes that some type of economic arrangements for paying the doctors, either under government or private auspices, would be necessary so that all people could have a personal physician. Specific payments for regular prenatal, post-natal, and well-baby visits would encourage doctors to provide supervision. It is further suggested that supervision could be continued all through the pre-school period when attention to growth and development is so important.

Consultant obstetric and paediatric care is either difficult to obtain or unavailable in several of the areas visited. It is suggested that in areas where private practice has been unable to attract these specialists, they be attached to the regional health services organization, as outlined in Chapters II¹ and V.²

School Health Service

General

The Public Health Act³ requires the local health department or unit to make an annual sanitary inspection of all school buildings within its jurisdiction. Special detailed forms are provided for the use of the medical officer of health and sanitary inspector whose duty it is to carry out the inspections. These forms include provision for recommendations. The reports are sent to the Ontario Department of Health.

Other services may be provided by agreement between the local board of health and the local board of education. However, in a very few areas, the boards of education may continue to provide school health service if these meet acceptable standards and were in existence before July 1924, or if special arrangements are approved.

The programme may include a school medical and public health nursing programme or public health nursing service only. Many areas now arrange for a physical examination of the student by the family physician at the time of entering school. Where this is not provided, the parents are requested to consent in writing to an examination by the school medical officer, if one is available, and, if not, for superficial "physical inspection" by the public health nurse. Subsequent examinations by the school medical officer and/or school nurse are provided according to local programme policy.

In most full-time programmes, routine vision and hearing tests are done periodically during the school life of the child with referral for medical opinion if deviations from normal are discovered. The public health nurse devotes time to health counselling and health teaching as well as conferences with teachers.

¹See p. 36.

²See pp. 79-80.

³Revised Statutes of Ontario, 1961.

In some of the larger municipalities and health units, a school dental service is provided. Though this is usually restricted to dental education and visual inspection with referral for treatment, some areas provide treatment which may even be available to all children in the school system.

Some boards of health and some school boards, especially those of larger cities, provide mental health consultant services for the school age group. This may be a service provided directly by the board of education or by arrangement with local mental health clinics under local public health, provincial Department of Health, or voluntary auspices.

Discussion of Field Study Findings

In the rural areas with part-time medical officers, only the required annual sanitary inspection may be carried out.¹ Few, if any, personal school health services may be provided. Even in urban, part-time programmes, the services may be relatively limited, whereas the full-time departments and units were found to be providing extensive programmes of physical health supervision, and sometimes of mental and dental health supervision as well. These last are seen as among the most pressing community needs by both health, education, and related social service² personnel in areas where programmes do not exist or are rudimentary.

The trend in well-developed school health services is away from routine physical examinations by department staff and to a programme of screening with subsequent referral for correction of any defects found, of immunization level maintenance through routine booster doses, and of personal health counselling of students. This last is a field which both teachers and health department staff members feel requires expansion.³ It is urged that routine physical examinations be done by the family physicians, wherever possible. In most communities this is now the policy with as many as 70 to 75 per cent of such examinations being carried out by family physicians. However, the remaining children, for a variety of reasons, some of them economic and some of them lack of interest on the part of parents, are not so examined and must be seen through the school system. If this newer approach is to be fully developed some type of financial arrangement whereby the cost of such examinations is specifically covered is needed. Some insurance schemes now operating do not cover preventive examinations of this type.

Some of the routine screening work could be done by registered nursing assistants rather than by public health nurses. It has been suggested that teachers might also do routine screening. However, this is not too realistic since care must be taken not to waste the time of skilled teachers. They already perform a number of activities not directly related to education in some communities.

¹Even this is reported to be fairly perfunctory in some places.

²For example, Children's Aid Society staff. For example, see Appendix I, p. 216. Appendix II, p. 256. and Appendix III, p. 296.

³Both point out the need for readily available psychiatric, psychological, and social work consultation for more serious cases. Several communities visited did not have these and the resultant burden fell on the public health nurses who are not equipped to handle it. For example, see Appendix I, p. 184. and Appendix III, p. 276.

Some schools would like to have a nurse present at all times to provide first aid and minor care for cuts, headaches, and so on. This is not an economic use of either public health or registered nursing time. An arrangement with local physicians and hospitals where extensive care is needed and for athletic events is suggested. The giving of first aid for simple problems occurring during classes by all teachers or by a special teacher in each school is more realistic in terms of skilled nursing time. This would not waste much time for teachers since accidents in school teaching hours are relatively few in number. However, the legal implications would need clarification, since some legal authorities feel it to be illegal for teachers to give minor routine care.¹

Several of the large urban municipalities in the Metropolitan Toronto area have full-time school mental health services which provide diagnosis and treatment for school children found to have psychological disturbances.² The health department service in the City of Toronto serves the separate schools only, whereas the extensive service for the public primary and secondary schools is provided separately by the Board of Education. In several urban municipalities in Metropolitan Toronto and in Peterborough school children may be referred to community mental health clinics, which are operated by the Ontario Department of Health, local health departments, or separate voluntary bodies.

School dental services, aside from some health education, are provided in some of the larger municipalities only. These vary from a superficial inspection by the school nurse, with referral notes being sent to parents where care is indicated, to programmes which employ dental health officers and dental assistants. The latter programmes usually consist of routine dental checks on children in specific grades, with notes being sent to the parents where care is indicated. Such programmes provide direct treatment only to children from low income homes, as for example, the City of Toronto dental service.³

As an exception to the general pattern, for some years North York Township⁴ has provided, through an approved additional property tax, a complete examination and treatment service for any children whose parents desire it. Dental facilities exist in most of the schools. The cost of this programme accounted for about one-third of the total health department budget of \$356,893.00 in 1961.

Smaller municipalities in Metropolitan Toronto refer children from low income families who require treatment to the clinic of the University of Toronto Faculty of Dentistry. The clinic does not take all patients but only those who would be good teaching material. It is not a charitable service primarily but a teaching unit supported by the university. Waiting periods even for semi-emergency care are several weeks at times.

¹It is understood that in the City of Toronto teachers are forbidden to do so.

²See Appendix IV, p. 313.

³See Appendix IV, p. 315.

⁴*Ibid.*

Hospitals with dental departments are relatively few and provide chiefly emergency care. Even those with extensive services, such as the Hospital for Sick Children, must screen cases carefully. Thus, in practice a relatively high proportion of children needing care must be refused assistance at both the university clinic and hospital departments.

In the rural communities and in smaller urban centres parents of children with dental problems are urged to obtain care for them. However, no special arrangements exist for those in low income groups. The more urgent cases receive care arranged on an *ad hoc* basis with individual dentists who provide free care or receive some remuneration through donations from service clubs. Any school board in Ontario can arrange with a board of health to establish a school dental programme and receive reimbursement by the provincial Department of Health, through the local board of health, for 30 per cent of any expenditure up to \$2,000.00 per year. Some rural municipalities make use of this grant and make arrangements with private dentists to provide the care. Unless a community is quite small, the grant does not make a very extensive service possible and there is the further problem that the community must provide the other 70 per cent of any expenditure from local tax sources. This last requirement, in practice, means that only a relatively few communities use the grant. Dental care, not only for children but for the population in general, is one of the serious health problems in rural and smaller urban communities.¹

Public Health Nursing²

The teaching and preventive work has been described under the specific public health programmes. In this section, reference is to visiting nursing service.

In large cities, such as Metropolitan Toronto, visiting nursing groups, the Victorian Order of Nurses and the St. Elizabeth Visiting Nurses Association, provide a generalized home nursing service, covering preventive supervision, teaching, and bedside care. However, even in medium-sized cities, visiting nursing association staff are usually few in number. For example, in Peterborough there are three Victorian Order of Nurses nurses, and in Teck Township (District of Timiskaming) there is one only. In rural areas and most small urban communities, the visiting nursing associations do not exist. In the rural areas visited, visiting bedside care is provided through *ad hoc* arrangements made by individual doctors and families with nurses living in the community. To a limited extent the public health nurses may provide some short-term care for special groups, such as cancer patients or the aged, or in some health units for any patient.

In medium and smaller urban communities, the duplication of effort and division of nursing service into a public health nursing service and a small Victorian Order of Nurses service is unwarranted and wasteful. The matter of adequate supervision of the small Victorian Order of Nurses staffs also arises

¹See Chapter III, pp. 51-53, for a discussion of dental care for the general population in rural and smaller urban communities.

²For specific programme details in the four communities studied, reference should be made to Appendixes I-IV, pp. 173-317.

though some degree of supervision from the provincial Victorian Order of Nurses staff is provided for all small units. In these communities and in rural areas, it is suggested that the health department or health unit should provide a generalized nursing service, including visiting nursing care. This suggestion would be particularly valid if the practice of public health nurses assisting doctors with their maternal and child health care were established.¹ The same public health nurses would provide both preventive and visiting bedside care to people.

In large cities, where the visiting nursing associations have extensive programmes and in some cases predated in origin the public health nursing service, there may be historical and personal reasons for maintaining their separate identities. However, some precise agreement should be made whereby overlapping of service and duplication of effort are eliminated. Co-ordination of work could be achieved either by amalgamation under the health department, if agreed upon, or by a purchase at cost of defined services from the associations by the health department. Visiting nursing association nurses working under the latter type of arrangement could be assigned districts and provide a full preventive, teaching, and bedside care in their districts, as would the public health nurses in their districts. Alternatively they could provide only bedside nursing care over the entire community and the public health nurses would then provide preventive services over the entire community. The precise arrangement should be a matter for local decision but some suitable arrangement should be required. Visiting nursing is now recognized as a basic community service and, to an increasing extent in most areas, is supported by public funds through grants and fees paid for services to residents who are welfare allowance recipients. The financing of this basic programme should no longer depend even partly on the uncertainties of voluntary fund raising.²

NEWER PROBLEMS IN PUBLIC HEALTH

Although some community health departments are developing programmes to meet some of the newer community health needs in fields, such as chronic disease, care of the aged, home care, mental health, rehabilitation, mass screening and multiphasic screening, accident control, and family planning, they are still relatively few in number. Health education activities need to be expanded. Liaison functions among the various community services should be developed further. These are some obvious areas in our view for an extension of public health action, since effective results depend as much on adequate planning and organizational knowledge as on technical skills. Reference is made under other sections of this study to potential public health functions.³ The needs for services are clear. The time for planning and action is now!

¹See pp. 25-26.

²For example, a report in *The Globe and Mail*, Toronto, March 1, 1963, points out that the United Community Fund of Greater Toronto has had to cut 1963 allocations to a number of agencies, including the Victorian Order of Nurses. The Toronto Branch has had to reduce its nursing staff from 123 to 105 and indicates that further reductions may become necessary.

³See Chapter II, pp. 33-50, and Chapter III, pp. 51-68.

RELATIONSHIPS WITH OTHER ORGANIZED COMMUNITY SERVICES

Relationships with other organized community health services are chiefly developed on a personal level and, thus, vary from place to place. Though the personal element is essential and will always remain the final means of good co-operation, it is felt that some type of formal administrative structure, which draws together the various organized community health services would make co-operation and co-ordination easier to achieve. Many of the current questions as to whether health departments or hospitals or some other community agency should provide services in these latter fields would be eliminated, since the services would be provided in common. Specialized personnel would be used in common. The present separation of services is wasteful of money and personnel and should not be permitted to continue. In our opinion, these objectives would be accomplished by the formation of a regional health services organization,¹ which would include the hospitals, the public health department, and other organized programmes, such as rehabilitation, home care (including visiting nursing), mental health, care of the aged, and ambulance service.

¹See Chapter IV, pp. 69-73.

COMMUNITY HOSPITAL SERVICES

GENERAL PATTERN

Hospitals in Ontario¹ may be classified into four categories—public general, public special, private, and federal. Public general hospitals may be owned and operated either by lay voluntary associations or corporations, by religious bodies or associations, by municipalities, or by the Province. They provide services of a generalized type to the public on a non-profit basis.² Public specialized hospitals are owned and operated under similar non-profit auspices but restrict their care to a particular disease or patient category.³ Private hospitals are operated for private gain and may be owned either by lay individuals and associations, or, occasionally, religious associations.⁴ Federal hospitals are owned and operated by departments of the Dominion Government to provide either general or specialized services for special groups of people for whom the Dominion has health care responsibility, such as veterans, Indians and Eskimos, workers on federal works projects, and the armed forces.⁵

The Ontario Hospital Services Commission, which reports to the Legislature through the Minister of Health but is administratively separate from the Ontario Department of Health, has two main responsibilities. In the first place, it administers a hospital care insurance plan on a shared cost basis with the Dominion. Membership in the Plan is compulsory for people employed by an organization with 15 or more employees. An employer with between 6 and 14 employees may request the Commission to enrol them. Premiums are deducted from payrolls and sent to the Commission by employers. Other people may apply

NOTE: The source of all of the following footnote data is *Canadian Hospital Directory, 1962* (Toronto: The Canadian Hospital Association, 1962), p. 13, Tables 1 and 2.

¹Of 319 hospitals, 115 with 2,745 beds set up had fewer than 50 beds each; 59 with 4,153 beds had between 50-99 beds each; 59 with 8,113 beds had between 100-199 beds each; 30 with 7,219 beds had between 200-299 beds each; 22 with 7,940 beds had between 300-499 beds each; 34 with 37,672 beds had 500 or more beds each.

²Of 190 institutions with 31,601 beds set up, 122 with 16,226 beds were lay, 45 with 9,423 beds were religious, 22 with 5,887 beds were municipal, and 1 with 65 beds was provincial. 22,764 beds were general; 1,581 were chronic; 465 were mental; the remainder included orthopaedic, contagious, and convalescent beds.

³Of 59 institutions with 30,578 beds set up, 25 with 4,818 beds were lay, 8 with 1,754 beds were religious, 3 with 299 beds were municipal, and 23 with 23,707 beds were provincial. 22,764 beds were mental, all but 26 in provincial mental hospitals; 3,980 were chronic; 3,101 were tuberculosis beds, of which 2,333 were in lay sanatoria; 583 were convalescent; 150 were general beds.

⁴Of 55 institutions with 1,787 beds set up, 50 with 1,625 beds were lay (chiefly general, chronic, and mental beds), and 5 with 162 beds were religious.

⁵Fifteen institutions with 3,876 beds set up, of which 2,330 were general, 902 mental, 528 chronic and 116 tuberculosis.

directly for either individual or family coverage and pay premiums directly on a quarterly basis. Coverage is dependent on payment of the premium in advance. New members are protected from the first day of the third month after the initial premium has been received. As of February 1963, some 97.3 per cent of the population of Ontario are reported to be covered for all necessary in-hospital services, excluding payment of private doctors, and for emergency out-patient care with necessary follow-up within 24 hours of an accident.¹ Municipalities may either pay the premiums for indigent residents or alternatively pay their bills, if in hospital, at a set *per diem* rate. The Province pays the premium for those on categorical assistance allowances.

The second task of the Ontario Hospital Services Commission is to develop a hospital system to meet the needs of the province. This is the responsibility of the Hospital Services Branch which has two divisions. The Hospital Consulting Services Division provides expert consultant advice and assistance to hospitals on different aspects of administration and service. The Hospital Planning Division approves plans of hospital construction, expansion, and renovation for provincial and federal grants. It also collects data on such matters as bed use, etc., and conducts studies related to its planning functions. For planning purposes, the Commission has classified active treatment hospitals into three operational categories. Community hospitals are small or medium-sized ones which serve a local community and provide chiefly general medical, obstetric, and minor or relatively minor surgical services. District hospitals are larger ones in larger communities which, in addition to a local community service, also serve as referral centres for certain purposes because of their more specialized staff, equipment, and range of services. Regional hospitals² are large ones in university centres and certain other cities which provide a full range of specialized services. A regional hospital acts as a referral centre for an extensive surrounding area as well as providing more general services in its own community.

DISCUSSION OF FIELD STUDY FINDINGS

Staffing and Services

Medical Staff in Rural, Smaller Urban, and Isolated Communities

One of the serious problems outside larger urban communities is the relative and sometimes total absence of qualified specialists of all types, including even the basic ones—the general surgeon, the internist, the obstetrician, and the paediatrician. This situation makes it difficult to develop quality supervision of hospital work, through staff committees, for example, a tissue committee or an infant mortality committee. It also makes it hard to establish a policy limiting the nature of work which doctors with different degrees of training may undertake.

¹As reported by the Minister of Health to the Ontario Legislature, February 1963. Care in tuberculosis sanatoria and in mental hospitals is covered under the Ontario Plan but the Dominion does not share the cost.

²Ottawa, Kingston, London, Toronto, and Hamilton are regional centres. Windsor and Sudbury are regarded as sub-regional centres.

³For specific details on the four communities studied, reference should be made to Appendixes I-IV, pp. 173-177.

An illustration of some of the difficulties is seen in one town visited.¹ It has a hospital of 40 to 60 beds with limited nursing and ancillary personnel and necessarily limited facilities. There are fewer than six doctors using the hospital, most of whom have had some practical surgical experience but possess no formal qualifications. On enquiry as to the type of work performed in the hospital, the reply was that all major surgery, such as neurosurgery, spinal work, and cardiac surgery, was referred to Toronto or to the largest hospital in the region. Only procedures, such as gastro-intestinal surgery were carried out locally. The doctors in this community are competent and honest practitioners. In an era when communications were less adequate, undoubtedly they had to undertake such procedures. However, in terms of modern practice and transportation this pattern is open to serious question.

Such a hospital, even if of sufficient size, usually cannot meet the requirements of the Canadian Council on Hospital Accreditation on medical staff functions.² All the doctors using it regard themselves as comparable in status and tend to be reluctant to accept even limited review and other quality controls by colleagues, who are as well competitors. Even where the doctors work in groups, there sometimes appears to be reluctance to have members of one group review work by members of another group.

In some areas, it is interesting to find several less common types of specialists, such as radiologists and pathologists, but few, if any, certificated or fellowship surgeons, paediatricians, obstetricians, and internists. The specialties of radiology and pathology require very specialized skills and really are staff type services for the other doctors. As such they present no economic threat. In rural and isolated areas and districts, it seems clear that these latter specialists can be attracted, if assured of sufficient work and incomes. For example, in the Timiskaming District the two radiologists serve the hospitals in the Timiskaming area as well as a number outside on a weekly scheduled basis.³ On this basis they have more than enough work to do and feel that their incomes are adequate.⁴ Likewise, the pathologist in Haileybury provides service to the Haileybury and to the New Liskeard hospitals⁵ and the pathologist in Kirkland Lake provides service to the Kirkland Lake and Englehart hospitals.⁶ On the other hand, in other areas comparable arrangements do not exist and these specialists are not found.

If there were a regional health services organization, such specialists could be attracted more easily, since they could thereby be assured a sufficient volume of work and a sufficient income. Depending upon the local circumstances, the

¹For obvious reasons, this particular reference has been modified somewhat to disguise the actual location of the hospital described. No particular purpose would be served by identifying it specifically since it is used merely as an illustration.

²The Council is presently working on a plan for accrediting small hospitals.

³See Appendix III, p. 281.

⁴The arrangement appears to be working satisfactorily. There, however, is a potential danger in such situations that a radiologist could offer to serve so many hospitals that he does little but read reports, since it may be financially more rewarding to hire technicians to do the actual radiological work. This situation would raise questions of supervision and quality of work done. A regional pattern would eliminate this potential danger in the present, relatively unplanned arrangements.

⁵See Appendix III, p. 281.

⁶*Ibid.*

method of payment could be either a full salary arrangement or an agreed consultation fee arrangement with or without a basic salary. The radiologists and pathologists would be available to all the doctors in the area and not just to those attached to one particular hospital.

A regional arrangement for the retention of specialists could also be used for other less common types of consultant, such as orthopaedic surgeons, psychiatrists, ophthalmologists, otorhinolaryngologists, urologists, and dermatologists, who need a relatively large population for a full-time consultation practice. The evidence of group practice prepayment plans in the United States is that approximately 35-60,000 people, depending upon geographic and demographic factors, are required to support such services fully.¹

The specialists should have their offices and facilities at the base hospital for the region. Otherwise there might be attempts by each of the individual hospitals to obtain separate special equipment and facilities. This would be economically wasteful.

The question of attracting basic specialists, such as pediatricians, obstetricians, internists, and general surgeons, is a more complex one. If they come to rural and small urban communities, they usually have to do a good deal of general practice in order to earn acceptable incomes. Thus, they are in competition with their colleagues. In turn, these colleagues are reluctant to refer patients to them since the patients may become the general practice patients of the specialist and not return to the referring family doctor following the consultation. Examples were cited, during the field visits, of specialists who had come to the smaller urban centres and rural communities but who were unable to remain because they did not receive enough referred work.

One answer would appear to be some form of group practice. In one area, a certificated surgeon had been attracted in this way.² However, there are limitations in that only the doctors belonging to a group may wish to refer patients to a specialist in the particular group. Doctors not in the group or in another group may be reluctant to do so. Group practice could be encouraged through long-term loans for facilities from government and from prepaid plans.

In more isolated and sparsely settled communities, it would appear to be necessary to consider attracting basic specialists on a regional basis as outlined above for less common types of specialists.³ They would act as consultants to the entire region. They should be paid a basic salary so that they would need to do only consultant work. Thus, there would be no economic threat to their colleagues in general practice but their presence would help the general men to provide a better standard of work. If the local economic and other circumstances warranted it, some additional income on a consultation fee basis could be developed over and above the basic regional retainer.

¹John E. F. Hastings, *Report to the Toronto Labour Health Centre Organizing Committee* (Toronto: Toronto Labour Health Centre Organizing Committee, 1962), pp. 20-21.

²See Appendix III, p. 281.

³See p. 35.

None of the areas studied had an absolute shortage of family doctors, though some had experienced temporary shortages from time to time. It remains to be seen whether the fellowship programme of the Ontario Department of Health, whereby medical students are given financial assistance for their education, and return a period of service in a rural area following qualification to practice, will provide a solution to shortages of family doctors in rural and isolated communities. It will no doubt be a help to recruitment for relatively well-populated rural areas which can support a physician in private practice and which are not too isolated in location. In sparsely settled, economically depressed, or isolated areas, however, it is unlikely to prove a sufficient attraction, unless in addition satisfactory hospital facilities, ancillary staff and services, reasonable referral arrangements¹ and living accommodation are made available and there is an acceptable basic income on a guaranteed salary basis.

A regional system of health services organization would make it possible to provide these additional requirements. Some family doctors attracted under such an arrangement might remain permanently because they find they like the life. However, it is likely, according to the experience of comparable programmes in Britain, Scandinavia, and elsewhere, that a majority would remain for between two to five years only, because of personal and family reasons as well as professional reasons. Together with the proposed regional specialist arrangement suggested previously,² this suggestion would none the less provide as satisfactory service as is possible under circumstances of isolation and scarcity of population.

The question of assuring basic medical and specialist services for isolated and sparsely settled communities and specialist services in rural areas and smaller urban communities is one which the medical profession and governments must face squarely. Present efforts are not solving the problem. Other possible suggestions are discussed in Chapter III.³

Registered Nurses and Auxiliary Nursing Personnel

In all four areas visited there are greater or lesser shortages of registered nurses⁴ for providing bedside nursing care in the hospitals. The problem is most acute during the summer vacation period and for night and week-end work.

Moreover, a variety of factors have created an artificial shortage over and above any actual shortage. Private nurses presently may spend more than one-half of their time on non-nursing activities. Skilled nursing time is not being used to full advantage when secretarial tasks are assigned or when nurses are asked to cover for shortages of other types of staff, such as in hospital pharmacies at night. Much private duty nursing could be eliminated if all hospitals provided necessary nursing on private as well as public sections. Better use of skilled nurses could be achieved by the wider use of such measures as progressive patient care and a re-organization of hospital wards and services on the basis of the degree of illness of patients rather than as at present into separate departments.

¹For example, readily available train, motor, or air ambulance service to a base hospital or to a large city hospital if required.

²See pp. 35-36.

³See pp. 51-53.

⁴As defined under The Nurses Act, 1961-62 (Ontario). Presently nurses are educated in university degree courses, in hospital diploma courses of three years length following either Ontario Grade XIII or XII standing, or at the Nightingale School in Toronto which is autonomous and provides a two-year basic course after Ontario Grade XIII.

One of the more serious shortage situations was seen at the Misericordia Hospital in Haileybury which had, at the time of the visit, 199 beds and a staff of only 25 registered nurses, including Sisters who were registered nurses. The registered nurses were engaged in supervisory work or in operating room work. Patients received bedside care from registered nurses only when quite ill. The inability to provide the standard of care which they felt people should receive was a matter of considerable concern to the hospital authorities. It was also a matter of wide-spread complaint by physicians and patients. Were it not for a large number of registered nursing assistants,¹ the hospital could not have operated fully. The hospital has been able to obtain registered nursing assistants in any number only because they offer a provincially approved training course. The graduates of such a course, because of the educational requirements for admission, content, and length of the course,² are able to assume only limited clinical care of patients and perform largely routine care and duties.

Other hospitals in the Timiskaming District³ and in Huron County⁴ had shortages of registered nurses but not to the same extent. In Peterborough and in the Metropolitan Toronto area there have been delays in opening some new sections in hospitals. During the summer period, in some cases, sections of hospitals have had to be closed temporarily because of an inability to obtain sufficient nursing staff.

In the larger urban centres especially, incomes and working conditions in nursing are not as attractive as in some other fields open to women. Salaries for registered nurses, with added increments for post-graduate training, need to be increased to a level comparable with other skilled work.

Outside the cities and larger towns an important factor appears to be the socio-economic status of an area. For example, communities, such as Goderich, Kirkland Lake, and New Liskeard, which have diversity in business and industry, attract families of higher educational status. In such families, some of the wives are graduate nurses. Communities which are predominantly mining or rural shopping centres only do not have the same attraction for such families.

Were it not for married nurses, shortages in all of the study areas would be acute not only in hospital nursing but in all nursing fields. There should be greater attention to the use of married nurses on a part-day basis, as is done already in many places. Courses to help nurses who graduated some years ago to refresh their skills, such as are provided by the Registered Nurses Association of Ontario are helpful. A regional pattern of health services organization would make such efforts easier to plan and effect.

¹Formerly known as certified nursing assistants. Under The Nurses Act, 1961-62 (Ontario), they are now known as registered nursing assistants. The provincial Department of Health has assisted certain hospitals, and technical or vocational secondary schools in association with hospitals to establish approved courses, and operates courses at several centres itself. As of October 1962, there were 39 approved courses of which five were Department operated, two were operated by vocational or technical schools, one by the Royal Canadian Army Medical Corps and the remainder by hospitals. See Appendix III, p. 285.

²The courses are ten months in length, except for several part-time evening courses of 12 months. The minimum requirements for applicants are completion of Ontario Grade VIII education, an age of 17 years, and a certificate of health. Some centres require higher academic qualifications. The courses must meet curriculum content standards and requirements on teaching staff. The curriculum has both theoretical and supervised practice components.

³See Appendix III, pp. 283-288.

⁴See Appendix II, pp. 241-250.

In all areas another factor is the greater variety of occupational opportunities open to girls than used to be the case. More young women proportionately need to be encouraged to take sufficient education to be able to enter fields, such as nursing.

There is considerable doubt in the minds of many educators as to whether the hospital courses, even in large hospitals, which are based on apprentice-type learning methods and may emphasize hospital service needs over the nursing students' academic requirements, are acceptable as modern educational settings. In other skilled professional fields the apprentice-type courses have almost entirely ceased to exist. One suspects that this may be a deterrent to girls who might otherwise consider nursing careers. From an educational viewpoint the establishment of independent schools, such as the Nightingale School in Toronto, which can emphasize the academic content of nursing education and still use hospital facilities for practical field experience, should be encouraged. University courses will continue to give valuable undergraduate and post-graduate opportunities to those who are academically qualified and who are considering possible careers in specialized fields, such as teaching, research, administration, and public health.

It is not within the scope of this study to consider nursing education facilities in detail. However, some comment is indicated on the problems observed in the smaller urban and rural communities, since educational and staffing questions are to a large extent interrelated. Small- and even medium-sized hospitals individually cannot maintain satisfactory nursing schools. They cannot obtain nurses with post-graduate education to conduct academic courses and to provide clinical instruction and supervision of an acceptable standard. They lack a sufficient variety in types of patient for teaching. It is, therefore, not practical for individual small, or even medium-sized, hospitals to operate their own nursing courses.

Regional nursing schools, operated independently of any one hospital, and provincially financed, possibly patterned after the Nightingale School in Toronto,¹ would provide an answer to the educational problem in rural and smaller urban communities. It would be reasonable, for example, in the Timiskaming area to have a regional school which could use the combined facilities of the hospitals in Kirkland Lake, Haileybury and, to a lesser extent, those in New Liskeard and Englehart, for practical experience. Likewise, in the Huron County area a regional school could use the facilities not only of the larger hospital in Goderich but also of the smaller hospitals in Wingham, Clinton, Exeter, and Seaforth. These schools could obtain qualified teachers² and clinical supervisors and could provide courses meeting acceptable academic standards. Some specialization within courses would also be possible under such a system. Regional schools could make arrangements with the nearest Ontario Hospitals for experience in the mental care field and the nearest sanatorium for experience in the tuberculosis field. Independent schools offering basic courses, such as the Nightingale School, would also help to provide additional nurses in the cities where existing hospitals already have courses.

¹The Nightingale course is a two-year basic course. Regional schools could be either of this basic type or could have additional specialized options during a longer course. Some specialization could also be offered through post-graduate courses.

²Some special teachers, medical and nursing, could be brought from larger centres on a block teaching schedule to the regional schools.

It is recognized that some existing schools, which are educationally inadequate, might be reluctant to discontinue courses. They could be encouraged to do so if a regional pattern of administration for hospital services and other health services were established. In some cases, a decision by the provincial authorities might be required.

A regional pattern would, of course, not guarantee that the nurses would remain in the area where they trained. However, a large proportion of the girls reasonably could be expected to remain, particularly if they married.

In Canada, little effort has been directed to attracting more men into nursing careers, except in special fields, such as psychiatry and urology. Even in these fields, many of the male nurses were trained overseas and have subsequently immigrated to Canada. A course at an independent school on a trial basis is suggested as a beginning.

Some consideration of the availability of subsidiary nursing personnel, such as registered nursing assistants and other auxiliary nursing personnel, is also indicated. These personnel in some hospitals outside the cities may form a high proportion of the nursing staff, as for example in Haileybury where there are approximately three for every registered nurse.¹ In hospitals in cities and larger towns the tendency is for auxiliary nursing staff to be fewer in numbers than are registered nurses. Their proportions in any hospital appear to be related largely to the availability of registered nurses. In city hospitals they chiefly carry out simple, routine aspects of bedside care and more skilled work is done by registered nurses. In rural hospitals, on the other hand, they may of necessity provide a large part of the bedside care. It was our impression that some of the hospitals in rural and semi-rural areas were operating courses for registered nursing assistants primarily in an effort to obtain staff and that standards were the bare minimum required for provincial approval. Smaller hospitals lack qualified teaching personnel and training opportunities for the girls taking the courses. The doctors in communities where smaller hospitals were offering courses expressed concern over the standards of the courses and the resultant skills of the graduates. In our opinion, such courses in small- and medium-sized hospitals should be discontinued.

Sometimes hospitals in desperation may provide unapproved auxiliary nursing training. These unapproved courses are at best an unsatisfactory "stop-gap" for meeting the service needs of hospitals and should be discontinued as quickly as possible.

As with registered nurses, the answer seems to be the establishment of large regional schools which could obtain qualified teaching staff and which would use the hospitals in the area for practical teaching. Such courses on a central basis have been established in some other provinces through co-operation between the provincial health and education authorities under existing federal vocational training legislation.²

However, there are other factors to consider. Some of the women who wish to take training as nursing assistants are tied to their own community by reason of marriage, owning a home, or family responsibilities. They are able to take training in a local hospital, but it would be difficult for them to leave the

¹See Appendix III, p. 285.

²Manitoba and Saskatchewan.

community and take training at a regional school unless it was within easy commuting distance. In order to bring these people, many of whom have a genuine interest in nursing, into regional training programmes, as much teaching as possible should be done in the local hospitals. This result could be achieved by having the teaching and supervisory staff go out to the hospitals for much of the course work. Only special academic work and special practical work would be provided centrally on a scheduled block basis of so many days per month and for short periods at the start and end of a course.

However, a re-organization of training arrangements will not meet the situation alone. If sufficient numbers are to be attracted, the work must be interesting and salaries must be attractive. Further attention should be directed to the type of training needed for registered nursing assistants and other auxiliary nursing personnel, based on further clarification of the type of work they should be allowed to perform. Additional study is also needed on the desirable proportion of registered nursing staff to auxiliary nursing personnel.

Some Other Professional Personnel

Even in many hospitals in cities visited, there were serious shortages of professional personnel, such as pharmacists, physiotherapists, occupational therapists, medical social workers, and university-qualified dietitians. In areas such as Huron County and Timiskaming,¹ they either do not exist at all or, at best, can be retained for short periods from time to time only. Incomes do not seem to be a major factor, except in the case of hospital pharmacists, since several of the hospitals visited were offering almost any salary and any facilities which a qualified applicant would wish but were having no success in getting such applicants. There are actual numerical shortages of qualified personnel.

The larger city hospitals are able to attract those available, partly because of the social amenities in a city but also because they offer work of sufficient variety and challenge. Moreover, in small- or even medium-sized hospitals, personnel, such as physiotherapists and dietitians, may be expected to assume too much responsibility for prescribing care on occasion because of a lack of understanding on the part of the doctors of their proper functions. Finally, the employment of special personnel by individual small- or medium-sized hospitals is not economically warranted.

On the other hand, it is clear that a region containing several hospitals would provide a sufficient volume of interesting work and would also make it economic to obtain such personnel. This type of arrangement would also overcome the problem noted in our field visits of doctors, who are not staff members of a hospital with physiotherapy and occupational therapy services, having to refer patients to doctors who were able to obtain these services for their patients. The result, under these circumstances, is that patients may not get referred.

A qualified, university household economics or household science graduate for example, could well serve all the hospitals,² other institutions, and even a home meal service in a region with the assistance, in the individual institutions,

¹See Appendix II, pp. 241-250, and Appendix III, pp. 283-288.

²For hospital dietitians, a broken internship of 3 months as a dietary department employee at the end of the first university year, 3 months with emphasis on purchasing at the end of the second university year, and a final 4-month supervised period is required by the Canadian Dietetic Association in an approved setting. In the case of the University of British Columbia course a one-year terminal internship in an approved hospital is required.

from graduates of food supervisors courses, such as that leading to a Diploma in Home Economics at the Ryerson Polytechnical Institute in Toronto.¹

Similarly, if attached to a regional health services organization, pharmacists, physiotherapists, occupational therapists, and medical social workers might serve several hospitals and other institutions, if these were reasonably close together. In the case of physiotherapy, it might also be possible to provide some home care services. The numbers of each type of personnel required in any region would depend upon the use to be made of their services as well as on the geographic area, transportation facilities, and the population to be served.

However, there are other considerations. Enrolments in existing university courses in household economics and social work are below capacity. Some pharmacy courses are not at capacity enrolment. Therefore, there should be greater encouragement and financial support by the Province and the Dominion to high school students to go on for further education and training, including careers in these fields.

The possibility of extending opportunities for supervised, adequately paid, hospital internships for more pharmacy graduates should be considered. This could be done under a regional hospital services pattern, since an experienced pharmacist at the regional base hospital could supervise the interns at the satellite hospitals. This would also permit rotation through the base hospital.

In the case of physiotherapists and occupational therapists, it is suggested that studies be made of existing educational facilities and of the possible addition of further university courses and the possible development of courses in technological institutes, such as the Ryerson Polytechnical Institute in Toronto. The latter institution has a two-year course in handicraft teaching which could be changed into a full occupational therapy course.² Of interest also is the special eighteen months course at Kingston, under the auspices of the Canadian Association of Occupational Therapy, which graduates qualified therapists.³

In general, it is our view that education in professional and skilled technical fields should be provided through educational institutions rather than under the auspices of professional associations. However, associations can play a useful role in establishing pilot courses and they should also be consulted on courses offered by the educational institutions.

Finally, greater attention in medical undergraduate education and in hospital medical staff education is needed so that doctors will understand better the functions of non-medical professional colleagues and not expect them to undertake responsibilities which are primarily medical ones. For example, in some smaller hospitals especially, non-medical professional workers, such as physiotherapists and dietitians, are sometimes expected to prescribe treatment because some doctors themselves may be uncertain about the precise recommendations to make.

¹Approved courses in food administration are also provided by the T. Eaton Company in Toronto, the Canadian Army, and the Royal Canadian Air Force.

²Graduates who take summer work on education subjects are eligible to teach craft work in schools. It is understood that a few are working in rehabilitation programmes.

³The course is supported by the National Health Grant programme and by the Province. It is open only to holders of a university degree or diploma, registered nurses, and those with a teaching certificate.

Hospital Administrators

One professional worker of particular importance to hospitals is the hospital administrator. Increasingly graduates of university courses are being appointed in larger urban hospitals. In Canada, the courses are provided at the Schools of Hygiene in the Universities of Toronto and Montreal.¹ Candidates must be graduates in arts, medicine, or the sciences with acceptable academic qualifications, aptitude, and experience. Enrolments are limited and graduates are, thus, available only to large hospitals and for other senior posts. The courses cover one academic year of nine months and a further supervised internship year which includes regular intramural seminars and an acceptable thesis.

The Canadian Hospital Association has fulfilled a valuable function for those already in the field, who do meet the requirements or who cannot take the necessary time for the university courses, by providing an extension course in hospital organization and management. The course covers two years of home study lessons and two intensive intramural academic sessions of a month in each of the years. Some of the hospitals visited had administrators who were graduates of this course or were planning to take it. It is, however, a demanding course and not entirely suited to the capacities and requirements of administrators in small hospitals.

It is suggested that a comparable course to that offered through the University of Saskatchewan for administrators of small hospitals of 50 beds or less be developed either on an extension basis through an Ontario university in co-operation with the Canadian and Ontario Hospital Associations or through the Canadian Hospital Association itself.

In general, it is our view that professional associations should seek to have responsibility for longer extension courses assumed by academic institutions and that they should provide such courses only on an initial pilot basis. On the other hand, there seems to be a definite role for professional associations in offering short courses, in-service courses, and refresher courses for professional, technical, and ancillary personnel.

A regional hospital organization pattern would permit employment of a well-qualified senior regional hospital administrator and of experienced extension course administrators for each large hospital. For a group of small hospitals, especially if accounting, purchasing, laundry and other services were centralized, less rigorously trained administrators in each small hospital could be supervised by one qualified administrator.

Medical Record Librarians

Medical record librarians are presently taught in Ontario at four approved² hospital schools with courses of 12 months following Ontario Grade XIII or its equivalent or following graduation from an accredited school of nursing or a normal school. Proficiency in shorthand and typing is also required. Since 1953, there has also been a two-year extension course, sponsored jointly by the Canadian Hospital Association and the Canadian Association of Medical Record Librarians. Candidates must have Ontario Grade XII standing or its equivalent and be employed during the course in an approved medical record department.

¹A course is being planned by the University of Ottawa.

²Approved by the Canadian Association of Medical Record Librarians.

Upon successful completion of a formal course at a school or the extension course plus an additional year of active work, the student becomes eligible for the examination as a registered record librarian set by the Canadian Association of Medical Record Librarians. Both types of course fit graduates for posts in larger hospitals and institutions.

With the development of more approved hospital schools, in 1963-64 the present extension course is to be replaced by a jointly sponsored¹ extension course of nine months designed for staffing smaller hospitals and for providing assistants in larger hospitals. It is to consist of home study lessons for eight and one-half months followed by a three weeks intramural session at an approved hospital medical record department. Those who complete the home study portion successfully receive certification as medical record clerks. Those who received 60 per cent or more on the examination and who have the Ontario Grade XII Secondary School Graduation Diploma or its equivalent may take the intramural course and sit for the examination for accredited record technicians. It is expected that this move will lead to greater numbers of candidates for training.

Medical Laboratory Technologists

Medical laboratory technologists in Ontario may train either in one of approximately 50 approved hospital courses² or at the Central Laboratory of the Ontario Department of Health in Toronto or the laboratory of the Hamilton Health Association. Training is for a minimum of 12 months but may extend over two years. Applicants must have Ontario Grade XIII standing or its equivalent, including chemistry, two mathematics, and either physics or biology. On completion of training the student may sit for the certification examinations of the Canadian Society of Laboratory Technologists. Successful candidates are qualified for annual registration as a registered technologist. Recently a course in medical laboratory technology has been jointly developed between the Ryerson Polytechnical Institute and the Ontario Department of Health. The course consists of one year of academic work in physics, chemistry, general microbiology, mathematics, and English at the Ryerson Polytechnical Institute followed by one year of practical training at the Technical Training Centre of the Ontario Department of Health Central Laboratory in Toronto. This course is designed for those who lack the necessary science and mathematics background for direct admission to one of the approved 12-month courses.³ Graduates receive a certificate in medical laboratory technology and are eligible for registration in the Canadian Society of Laboratory Technologists.

X-ray Technicians

X-ray technicians in Ontario are trained over two years under the supervision of a certificated radiologist and a qualified radiological technician in either diagnostic or therapeutic X-ray technique. An applicant must have the Ontario Grade XII Secondary School Graduation Diploma or its equivalent, including

¹Canadian Hospital Association and Canadian Association of Medical Record Librarians.

²Approved by the Canadian Medical Association's Committee on Approval of Training Schools. There are about 100 approved hospital schools in Canada. A number of universities outside Ontario offer either degree or certificate courses in this field. These are chiefly designed for specialization work.

³Applicants must have the Ontario Grade XII Secondary School Graduation Diploma or its equivalent. Training bursaries are provided.

mathematics and science, or be a graduate of a recognized nursing school. On completion of training the student may sit for the examinations set by the Canadian Society of Radiological Technicians in either diagnostic technique or radio therapeutic technique. A successful candidate becomes registered in one or other field. A further year of training permits joint qualification. There are approximately 40 hospitals approved as training centres for diagnostic radiography and four centres¹ approved for training in radiotherapy in Ontario.

General Comments on Medical Record Librarians, Medical Laboratory Technologists, and X-ray Technicians

Outside the larger centres serious shortages of qualified medical record librarians, X-ray technicians, and laboratory technologists were observed in almost every hospital. Most of the graduates of the formal courses in all three fields take jobs in larger urban hospitals rather than in small- and medium-sized hospitals in smaller cities, towns, and rural communities. As a purely "stop-gap" measure some of these latter hospitals are using people without approved formal training who have received some degree of in-service training in these jobs. Concern over this situation was expressed by doctors and hospital authorities wherever we visited.

A related problem is the limited, qualified supervision of technical staff members in several of the hospitals visited, especially in the laboratories and to a lesser extent in the X-ray sections. The quality of medical record keeping in these hospitals also in general leaves much to be desired.

A potent argument in favour of a regional hospital system is that it would permit a more efficient development of laboratory, X-ray, and medical record services in each region, including more effective professional supervision of technical personnel in smaller hospitals, and better general utilization of trained personnel.

General Comments on Personnel

A consideration of the whole field of hospital personnel described in the preceding pages raises several general questions for which we believe professional and technical associations and hospital authorities must find satisfactory answers.

With shortages in almost every field, it seems clear to us that the various professional groups should study intensively the possible and best use of more technically trained personnel. Unnecessarily restrictive professional association policies should not be permitted to hamper a reasonable use, under qualified professional supervision, of technically trained, auxiliary personnel. We note with interest, therefore, that the Ontario Hospital Association offers a full-time course of six months for training food supervisors and is studying the possible development of a ten-month correspondence course combined with one or two short intramural sessions at selected centres. Under the latter proposal, Ontario Dietetic Association members would serve as supervisors for trainees in their areas. These programmes are designed to meet the needs of smaller hospitals. A four-month course for occupational therapy assistants to assist in the Ontario Provincial Mental Hospital Service has been developed at the Ontario Hospital in Kingston. Candidates must have completed Ontario Grade X or its equivalent. Training bursaries are available. Possibly, comparable types of courses for auxiliary physiotherapy and occupational therapy personnel would be a useful development.

¹The Princess Margaret Hospital in Toronto and the clinics in Hamilton, Kingston, and Ottawa of the Ontario Cancer Treatment and Research Foundation.

We also note that short courses for other hospital personnel, such as surgical technical aids¹ and orderlies,² are being provided by some individual hospitals and for purchasing agents and other office personnel by the Ontario Hospital Association. These are all valuable contributions to the overall training opportunities in the province. The demand for comparable courses will undoubtedly grow as more and more types of technical personnel are required.

However, the multiplication of types of personnel, of courses, and of course auspices can lead, if it has not already, to an uncontrolled and confused situation in admission standards, in course contents, and in course purposes. Questions, such as these, should be asked: in an effort to achieve greater status have admission academic requirements to some established technical courses been set at too high a level? Is it realistic in terms of recruitment and in terms of the jobs to be performed to demand Ontario Grade XIII or even Grade XII standing for applicants to less skilled technical fields? What should be taught in the various courses? What tasks do we wish their graduates to perform? Who should be responsible for providing courses? Professional and technical associations? The hospitals? The Ontario Health Department? The Ontario Hospital Services Commission? The Department of Education?

If acceptable common standards of training and teaching are to be established and if problems of under-supply and possible over-supply of technical personnel are to be avoided, the Ontario Departments of Education and Health and the Ontario Hospital Services Commission should, in co-operation with the hospital, medical, and technical associations concerned, develop province-wide patterns of training. In turn, efforts need to be directed to establishing agreements on training standards with the other provinces. To some extent these things have been done but the picture is still largely a confusing one of unco-ordinated programmes.

Though we wish to commend the efforts of the various professional, technical, and government bodies who have developed training programmes, it is our view that in some fields there is undue emphasis on apprentice training at the expense of consistent academic standards. We, therefore, feel that the development of courses in association with academic institutions, such as the Ryerson Polytechnical Institute, is a trend to be encouraged as further regional institutions of this type are established. We recognize that there has been some professional resistance to suggestions for training X-ray technicians on other than the apprentice system through a central or regional school pattern. Nor has the development of the joint programme between the Ryerson Polytechnical Institute and the Ontario Department of Health for medical laboratory technologists been welcomed by everyone. The opening in the autumn of 1962 of a regional school for hospital laboratory technologists in Hamilton supported by five hospitals is also a development which may lead to the establishment of further regional schools.

Finally, it is suggested that a regional pattern of hospital services would facilitate the establishment of regional training programmes based on regional hospitals and provincial laboratories, to replace the smaller individual hospital courses. Courses in large hospitals with good supervisory and training facilities would, therefore, continue as a basic part of the pattern but courses in smaller hospitals would be merged on a regional basis. In some cases, one or two centrally located training courses may be the preferred solution for more

¹For example, the Toronto General Hospital and Hospital for Sick Children, Toronto.

²For example, the Toronto Western Hospital.

specialized training, for example, at such institutions as the Ryerson Polytechnical Institute and the Central Laboratory of the Ontario Department of Health. The actual patterns need careful planning. The point at issue is that planned and co-ordinated province-wide patterns should be developed.

Organization and Administration¹

An underlying problem in the hospital field is that of organization and administration. In rural and smaller urban communities, such as Huron County² and the District of Timiskaming,³ when transportation was less efficient it was a matter of necessity as well as local prestige to have a small hospital in most towns. Thus, in rural and semi-rural regions there are usually several independent small- and medium-sized hospitals.

As a rule, a medium-sized hospital in such a region at present is used only as a local general hospital and not as a referral hospital for the surrounding area. It has difficulty in obtaining special equipment and facilities and in attracting specialists to the staff. A small hospital in such a region can never expect to be able to provide the variety and level of services of a large hospital. Presently, accreditation is, therefore, either difficult or impossible to achieve, though the Canadian Council on Hospital Accreditation is endeavouring to develop accreditation standards for small hospitals.

In spite of these realities, efforts to rebuild and to renovate hospitals and to obtain costly equipment and scarce specialized personnel were observed in communities only a few miles apart. There is recognition by the local hospital boards and townspeople that their buildings, often old family residences, may be unsuitable and the facilities and equipment obsolete. But there is much less indication of a desire to co-operate with neighbouring communities in providing one modern hospital of reasonable size to serve them all, instead of trying to rebuild several small and necessarily less adequate ones. There is a deep attachment by citizens in towns and villages to their own hospitals in their own community. The doctors in such communities are often reluctant to lose their own hospital, in which there may be few limitations on the work they may carry out other than by their individual decisions. One finds also that the administrators of small hospitals usually have not had any formal training for their work. The pattern, just described, seen so commonly in rural and smaller urban communities, may have been warranted in the past but it is now uneconomic and inadequate as a way for providing modern hospital services.

In Metropolitan Toronto there are serious shortages in numbers of active treatment beds.^{4,5,6} This is particularly the case in the growing suburbs. The North York area, for example, at the present time has approximately 500 hospital beds of all kinds for a population that is growing at the rate of 20,000 a year

¹For specific details of hospital patterns in the four communities studied, reference should be made to Appendixes I-IV, pp. 173-317.

²See Appendix II, pp. 241-250.

³See Appendix III, pp. 283-288.

⁴Estimated in January 1961 to be 1,946 beds. (Summary of an address by Dr. John B. Neilson, Commissioner, Ontario Hospital Services Commission, to the Social Planning Council, Health Section, January 24, 1961.)

⁵Active and chronic care paediatric beds are reported to be in very short supply. *Hospital Accommodation and Facilities for Children in Metropolitan Toronto* (Toronto: Committee for Survey of Hospital Needs in Metropolitan Toronto, 1962, p. 42).

⁶Convalescent and chronic care facilities were stated to be in short supply by those interviewed.

and in 1961 was close to the 270,000 mark. Admittedly in a large city many people prefer to go to the large hospitals in the heart of the metropolis. But these increasingly are becoming specialist hospitals and the waiting lists for general conditions are often long unless the situation is an emergency.

Part of the problem is the relative shortage of alternative kinds of accommodation, such as supervised nursing homes, convalescent facilities, chronic disease facilities, and facilities for elderly and semi-senile patients. It is also related to the limited home care arrangements. A pilot project in the Toronto area has demonstrated that an organized home care programme can enable some people to be cared for satisfactorily in their own homes and to return home from hospital earlier than where no programme exists. However, when people are covered for care in hospital, home care and nursing home services will not be readily used unless they also have some type of economic coverage for this service. These ancillary services which relieve pressures on hospital beds should be covered under the Ontario Hospital Insurance Plan or on some other basis.

It is not an economic use of facilities to have empty beds in some hospital departments at the same time as there are beds in the halls in other hospitals, as can now be found on occasion under the allotment of bed by services and departments. Bottlenecks in transferring patients from one institution and facility to another are not uncommon. In a large city like Toronto, and also to a lesser but growing extent in a city like Peterborough, there is evident need for central planning of all beds within a hospital and of all hospital beds in the area, related institutional facilities, and home care facilities, so that the most efficient use of each type and ready transfer from one to another can be made.

The Ontario Hospital Association divides the Province into hospital regions which meet as councils in several instances¹ for discussion and planning of common problems but these are purely voluntary in structure. Thus, effective action on any proposals results only from the voluntary decision of each hospital board.

Efforts by the Ontario Hospital Services Commission and by local groups in some areas have been unsuccessful to date in persuading hospitals to develop a functioning, regional planning and administrative pattern for hospitals in Ontario. In many communities having two or more hospitals, there is no local body that has any responsibility for hospital planning. In some instances, such as Huron County, efforts to stimulate more interest in local planning have had little success. In Metropolitan Toronto there is no central hospital body, in spite of efforts on the part of the Ontario Hospital Services Commission to stimulate the development of such an organization.

A regional hospital system is, in our view, an essential development. Such a pattern would permit economies through group purchasing, accounting,² laundry,³ and other readily centralized services. It would make it easier to obtain qualified special professional and technical staff, including administrative staff. It would facilitate the co-ordination of services and the more efficient use of scarce personnel and facilities.

¹For example, Paris—Galt—Kitchener and Fort William—Port Arthur. See Chapter IV, pp. 69-73.

²For example, in Manitoba for hospitals under 75 beds central accounting is used.

³Central laundry facilities are being used by the hospitals in Kitchener, Galt, Paris, and Guelph, for example, at a saving over the cost when each either operated their own laundries or had laundry done commercially. The Toronto General Hospital provides laundry facilities for the Wellesley and Princess Margaret Hospitals and heating for Mount Sinai Hospital.

In rural and semi-urban regions, one of the hospitals could be developed as a base hospital in which the specialized equipment and staff would be located. The other hospitals would provide emergency care, general medical care, obstetrical care, and chronic care. Some small hospitals in old buildings should be torn down and, depending upon a study of the needs of a particular region, should not necessarily be replaced. Others could be converted into nursing homes.

In large cities several large central base and referral hospitals for surrounding regions or even a province or several provinces would be required. Other large general hospitals providing all but highly specialized services would be required in suburban districts surrounding the downtown central hospital complex.

Care would be necessary to assure that an acceptable agreement between local boards and the regional authority is reached, so that local control is retained in purely internal matters in any hospital, whether under lay or religious ownership and administration. On the other hand, parochial reasons, such as local pride and a reluctance by local doctors to lose presently unlimited hospital privileges should not be permitted to hamper reasonable planning and co-operation. It is our view that action by the Province will be required if the desired objective is to be achieved. Even so, changes do not always come readily.

Relations with Other Community Services

Hospitals do not always make the best use of the other organized health facilities in the community, such as the health department or unit, the visiting nursing groups, where they exist, and other voluntary agencies. It is also evident that these other services do not make the best use of the hospital facilities. For example, there is at times some overlapping of services, such as between the regional laboratory and hospital laboratories and between X-ray equipment in the hospital and health department.

In some Toronto hospitals, the local health department public health nurses in hospital health service departments act as a liaison with their local department. In some places the public health nurses visit obstetrical patients. In some communities there is a public health nursing office in the hospital. In a few communities newer hospitals or extensions on older ones include space for the health department.

In one community visited, the Victorian Order of Nurses unit has its office in a large hospital, though, in practice, communications with the hospital staff and the doctors are as yet rather limited.

Thus, relationships between hospitals and other community agencies tend to be *ad hoc* and personal in character and sometimes are not as close as they might and should be.

The provision of space for the health unit in the main hospital of a rural or semi-rural region is a practical way of encouraging closer relations. It cannot, of course, guarantee them. It is essential that both parties be involved in planning and that there be guarantees to assure that future expansion of either the hospital or the health unit will not result in the one being dispossessed. Thus, there should be assurance that suitable means for possible future expansion are included in the original plans and agreement. We suspect

that one barrier to the more rapid growth of joint housing arrangements is that some health officers and some hospital boards have not seriously considered them and that those who have sometimes are hesitant in making the suggestion.

It is our opinion that this is a development which should be actively encouraged by the Ontario Hospital Services Commission and the Ontario Department of Health in rural and semi-urban areas in particular. A regional administrative system for all organized community health services would make this easier to achieve.¹ There would be a base hospital in which the main health unit office could be located and surrounding community hospitals with facilities for a public health nursing office and clinics in each. In large cities, joint housing would not, as a rule, be feasible because of the size of each component but closer relations could be encouraged by the provision of public health nursing services in each hospital.

It is further suggested that the medical officer of health automatically be appointed a member of each hospital's honorary staff. He should be expected to attend meetings of the staff as a whole and be a member of such special committees on which his experience and training would make him useful, for example, an infections committee. It is also our view that it would be worth while for the hospital administrator of the main hospital in a region to be appointed as adviser to the public health department on matters affecting the hospitals.

Finally, in our opinion, closer relations with other organized services, such as rehabilitation, mental health, services for the aged, ambulance services, and home care would be easier to achieve under a regional health services arrangement which tied them together with the hospitals and health department. There are wide areas of mutual interest among all the organized health services which could be more readily harmonized than where each is a separate administrative entity.

¹See Chapter IV, pp. 69-73.

OTHER ORGANIZED COMMUNITY HEALTH SERVICES

DENTAL SERVICES IN RURAL AND SMALLER URBAN COMMUNITIES¹

It was not originally intended that the provision of dental services would be considered in this study, except as they are part of the organized health services in the community, for example, the school health service programme. This latter programme has been discussed already.² However, the field studies in the largely rural and semi-isolated areas clearly revealed that the relative scarcity of dental services is severe and is one of the most serious health problems in such communities, a problem which in many places is becoming steadily more acute. Consideration of the situation following the field observations and many interviews has led us to the conclusion that, as with certain types of medical specialist services,³ some type of organized community approach to the problem is required if it is to be alleviated.

What is the extent of the problem as illustrated by the field studies? In the District of Timiskaming⁴ with just over 50,000 people there are 11 dentists, several of whom are elderly and unable to carry as heavy practices as they once did. In recent years, two dentists have died. No replacements, let alone additional dentists, have come to the area to start practice, despite efforts on the part of the communities to attract them. In Huron County⁵ with over 53,000 people there are eight active dentists. After considerable local effort and the assistance of the Ontario Dental Association, an additional dentist is likely to start practising in the near future.

In both areas, many of the dentists are forced to restrict preventive and restorative care to people in their own towns and old patients. Those from rural districts and towns without dentists are given only emergency care. Even so waiting lists are long. Dentists are reported⁶ as saying that they are unable to provide the modern sort of dental health care they were taught as undergraduates because of the volume of work they are trying to handle. Their choice is either to come to a city where such practice is possible or to remain but largely forget preventive and restorative work.

¹For details on dental services in the communities studied, see Appendixes I-IV, pp. 173-317.

²See p. 28.

³See pp. 35-37.

⁴See Appendix III, p. 283.

⁵See Appendix II, p. 241.

⁶Interview with Dr. S. A. MacGregor, Professor of Paedodontia in the Faculty of Dentistry of the University of Toronto, Chief of Dental Services at the Toronto Hospital for Sick Children, Chairman of the Dental Committee of the Ontario Division of the Canadian Red Cross Society.

Of course, some people can go to nearby cities and towns outside the area in the case of Huron County but this is more difficult for those in Timiskaming. The difficulty is that dentists in these neighbouring communities are also very busy, quite aside from the time and cost factors involved in travel to them. Some Junior Red Cross rail cars serving isolated communities cannot be staffed at present though the Ontario Health Department dental rail cars are presently operating. Dentists for such work are extremely hard to find.

What is the possibility that under present circumstances the situation will improve? A large majority of dental students come from the large urban centres and are reluctant to live elsewhere. At a recent conference in Toronto¹ it was pointed out that of 31 in the 1962 graduating class of 110 at the University of Toronto Faculty of Dentistry whose homes were outside Metropolitan Toronto, only 11 came from centres of under 10,000 population. Of these four or five could be expected to establish practices in communities of under 10,000 people.

It is suggested that, in addition to increased encouragement and financial support for those considering a dental career, a salaried dental service, designed to attract new graduates to work for a time in rural and northern areas, be established. The dentist should have an office provided by the region in a hospital or, in the far North, in a rail car. He should receive a fair salary. In areas where there are some but insufficient private dentists, his work could be restricted to those in lower income groups. He must have convenient consultant arrangements for complex cases provided by experienced dentists who should visit regularly to help with more difficult problems. They could be retained in a region on the same salaried basis or a basic salary plus certain fee privileges as was suggested for medical specialists.² A further inducement to recruitment would be to offer graduate education fellowships to young dentists who have given two or more years of service in this programme. Communities wishing to attract a private dentist should assure him of a suitable office and living arrangements since these are sometimes hard to find.³

However, efforts to encourage dentists to serve for a time or possibly even to settle in rural and smaller urban communities will not be successful unless the underlying problem of insufficient numbers of dentists is remedied. The graduates of existing dental schools are too few in number to meet the service needs of the growing population. More dentists must be prepared. The salaried dental service can only serve the most seriously under-served areas and because of the expected regular turnover will not be as satisfactory a solution as permanent resident dentists would provide.

It is also suggested that intensive study of the use of auxiliary personnel be made. For example, denturists are licensed in Alberta and British Columbia for doing certain bridge and plate work and in New Zealand dental nurses may do routine fillings. It is clear that the dentist must learn to use the services of skilled assistants, if his time is to be used to best advantage.

It has been indicated that one serious barrier to recruitment of dentists is that the proportion of students from rural areas who attend university is only about one-third of the proportion from urban areas who do so. The basic need is

¹Ontario Dental Association, Dental Public Health Council Workshop Conference on Recruitment and Placement of Dental Graduates in Rural Ontario, November 21, 1962.

²See pp. 35-37.

³A dental unit, including living facilities either in a hospital or health unit building would be suitable. Such a self-contained unit with both office and living facilities could be built by a town and rented to a dentist at a reasonable rate.

for better teachers and educational facilities at both the primary and secondary levels in rural and smaller urban centres. Unless more students with better academic qualifications take further education, the future recruitment for service in rural areas not only for dentistry but for all professions and skilled fields, is likely to be bleak. Economic deterrents may also be an important barrier. It is suggested that a thorough study of educational facilities and opportunities for students in rural and smaller urban communities be done.

A serious problem, in both urban and rural communities, is that of finding suitable facilities for treating children and adults for whom general anaesthetic is often needed, such as those with cerebral palsy and mental retardation, or those who need medical supervision when dental procedures are performed, such as haemophiliacs and severe cardiacs.¹ Some large urban hospitals have dental departments but these are relatively few. Moreover, those that exist may not be extensively used.² The authors did not have time to look into the matter in detail. Part of the difficulty appears to be resistance on the part of some medical staffs to making beds available for dental purposes. Further study of the problem is suggested. It is, however, our general suggestion that the base hospital in each region provide facilities and beds for people who require medical supervision and/or general anaesthesia for dental procedures.

Many of the people interviewed in all four study areas spoke of the problems of getting preventive and restorative care for children and adults in lower income families. Some arrangements can usually be made for wards of the Children's Aid Societies through the co-operation of local dentists. Under general welfare assistance legislation only emergency care is paid for. Financing new dentures and repairs is difficult to manage for elderly people dependent on the Old Age Security pension and even for those with modest additional income. Often service clubs and other groups must be asked to assist. Sometimes they can help and sometimes they cannot. Public health nurses and others spend a good deal of time trying to make such arrangements. These matters are difficult to solve in all communities but in areas where, in addition, dentists are scarce, the difficulty is greatly increased.

It is our opinion that the entire pattern of paying for the care of people on general assistance and on various categorical allowances should be altered to provide a full range of preventive and restorative dental care, including dentures, on other than a charitable and haphazard basis.

REHABILITATION³

Until recently rehabilitation facilities in Canada except for specific groups of people such as injured workmen, the armed services, handicapped veterans, the blind and certain other groups were limited. However, in recent years there has been a tremendous mushrooming of interest and facilities in the general field of rehabilitation.

In Ontario a branch of the Ontario Department of Health will provide financial assistance for medical rehabilitation to those patients suffering from tuberculosis or mental illness. It is also active in encouraging the development of

¹*Hospital Accommodation and Facilities for Children in Metropolitan Toronto* (Toronto: Committee for Survey of Hospital Needs in Metropolitan Toronto, 1962), p. 52.

²For example, the department in the Peterborough Civic Hospital is reported to be only used to a small extent.

³For details on the rehabilitation services in the communities studied, reference should be made to Appendixes I-IV, pp. 173-317.

community services.¹ Previously some vocational rehabilitation has been provided for some years under the Tuberculosis Prevention Branch. Ontario also has an agreement with the Dominion Government under the Vocational Rehabilitation and Disabled Persons Act. Under its provisions,² and those of the Ontario Rehabilitation Services Act comprehensive rehabilitation services³ for all types of disability are provided through the Ontario Department of Public Welfare. Rehabilitation counsellors are stationed at the Department's regional offices throughout the Province and visit referred clients regularly. Those covered under the Workmen's Compensation Act of Ontario and the Veterans Rehabilitation Act of Canada are excluded from this programme. Under the General Welfare Assistance Act of Ontario, needy unemployed or unemployable people not eligible under other legislation, may receive vocational training, re-training, and prosthetic appliances. Financing is jointly by the Province and municipality of residence. The National Employment Service provides a special placement service for handicapped workers through its area offices.

Under the Workmen's Compensation Act, workers injured in industry or disabled by occupational illness are entitled to all necessary medical care, compensation, and vocational rehabilitation. A large rehabilitation centre is operated by the Workmen's Compensation Board near Toronto. Local facilities are also used where these are available. The Board's rehabilitation officers work closely with employers and unions, from the main office at the Downsview Rehabilitation Centre and from district offices, in an effort to place injured workmen in suitable employment, if they cannot return to former jobs.

The Department of Veterans Affairs, through regional offices and Sunnybrook Hospital in Toronto, provides physical and vocational rehabilitation services and prosthetic services. The general public may use the latter at reasonable cost.

Most local health departments carry out case finding and referral services through the maternal and child health and school health programmes and, where provided, through the services for older people. In a few instances, such as Ontario County, they have been instrumental in promoting the establishment of area rehabilitation councils.

It is not within the scope of this study to describe in detail the many voluntary agencies providing rehabilitation services in Ontario. A variety of voluntary agencies provide physical, vocational, and counselling rehabilitation services of varying degrees for many types of patient, such as crippled children, orthopaedically disabled adults, the blind, paraplegics, rheumatic and arthritic cases, and cancer cases. Some have sheltered employment and limited residential facilities. Some of the larger agencies are nationally and provincially organized. Some operate rehabilitation centres and employ regional staff, in addition to the work done by volunteer community groups.⁴ Other agencies provide chiefly counselling and certain personal services for sufferers from the particular

¹Regional rehabilitation conferences which brought together interested government, professional, hospital, public health, and voluntary agency groups have been held in early 1963 in the Fort William—Port Arthur (Lakehead) and Ontario County—Oshawa areas.

²The Dominion reimburses the Province for 50 per cent of the cost.

³Including assessment and counselling, restorative services, prosthetic appliances, vocational training, and social services. Maintenance allowances during assessment, treatment, and training are provided.

⁴For example, the Ontario Society for Crippled Children, the Canadian National Institute for the Blind, the Rehabilitation Foundation for Poliomyelitis and the Orthopaedically Disabled, the Canadian Arthritis and Rheumatism Society, etc.

diseases they have been established to serve.¹ Smaller disease-oriented agencies may provide chiefly information and some counselling from central provincial offices. Many agencies are active primarily in promoting research and some in assisting professional education.

Finally, in more and more urban hospitals, physiotherapy is available to patients. In a few large urban hospitals, usually teaching hospitals, extensive in-patient and, in some cases, out-patient rehabilitation services are provided. These may include social counselling, day care, and home services.² In-hospital services in Toronto and Peterborough³ are developing rapidly and with encouragement and greater availability of staff, should continue to do so. A number of specialized rehabilitation centres in Toronto and other large cities, usually university teaching centres, provide services for all of Ontario and to some extent adjacent provinces. However, if hospital and specialized facilities continue to develop on a separate and unco-ordinated basis, duplication of facilities and waste in the use of scarce skilled staff may result.

For certain diseases where the numbers of patients are relatively few and care is highly specialized, special centres such as the Lyndhurst Lodge Hospital programme for paraplegics in Toronto, serving an entire province or even an entire country, have shown to be effective answers. Thus, for example, the numbers of severely disabled thalidomide children are such that one or two centres in Canada might prove the wisest way for developing the special skills required for coping with their particular problems. On the other hand, for a wide range of less specialized conditions, more generalized centres and departments seem to provide a satisfactory service, as, for example, the Toronto Western Hospital programme.

One approach would be to establish a grouping of specialized facilities around a more general centre, as is to some extent occurring in the north Bayview Avenue area in Toronto, where several government and voluntary centres have been built near each other. This could permit common use of scarce staff and special equipment and prevent duplication of supportive services, such as prosthetic services, provided that administrative arrangements were conducive to co-operation. In large urban communities, well developed hospital programmes, in-patient and out-patient, for less specialized types of rehabilitation problems are also necessary. The essential point, however, in a large urban community is that rehabilitation should be provided on a planned and co-ordinated area-wide basis. Highly specialized facilities should be planned and co-ordinated on a province-wide basis or even in some instances on a nation-wide basis.

The present problem in most rural and semi-urban communities is that even routine rehabilitation services are virtually non-existent, because of problems in obtaining qualified personnel and because the hospitals operate as separate entities.

It seems clear that it is unrealistic to try to provide even basic rehabilitation services in each small- and medium-sized hospital. A regional rehabilitation service pattern provides the only realistic answer to the most economic use of

¹For example, the Ontario Cancer Society, the Ontario Tuberculosis Association, etc.

²For example, the Toronto Western Hospital.

³See Appendix I, pp.188-193.

staff and facilities.¹ Moreover, only basic and straight forward problems should be handled in these regions, either on an in-patient, out-patient, or home care basis. Since rehabilitation services are required not only in the hospitals and other institutions but also in home care programmes, it is suggested that these should be provided through a regional health services administration, in common with hospital, public health, and other basic services.² Complex cases would be referred to large general and specialized rehabilitation centres in large cities, especially medical teaching centres.

A related urgent problem is the almost total lack of suitable living accommodation for severely handicapped older teenage children and young adults. A number were found to be living in homes for the aged because no other accommodation was available. Suitable facilities for severely handicapped children are also scarce. Suitable accommodation should be provided as part of any regional health service pattern.

The question of the role of voluntary agencies in rehabilitation also arises.³ In the rural and semi-urban areas visited, activities, except for periodic visits by field staff and/or periodic diagnostic and follow-up clinics in the case of a few large province-wide agencies, were found to be chiefly in the fields of general public education, fund raising, and providing for the small needs of patients in the area, such as dressings, drugs, food supplements, and so on.⁴ Agencies providing extensive clinic and physical medicine services are finding it increasingly difficult, with a few exceptions where fund-raising techniques have caught the public eye, to obtain sufficient funds solely from voluntary sources. Grants from all levels of government are becoming increasingly necessary as part of their revenue sources. Under the proposed regional health services organization, voluntary agencies should either have services purchased from them by the regional organization under specific terms and standards or devote themselves solely to other important activities such as pilot projects, public education, patient visiting, and the meeting of small personal needs for patients.

MENTAL HEALTH⁵

The Mental Health Branch of the Ontario Department of Health operates a system of hospitals for the treatment and custodial care of mentally ill patients requiring long-term psychiatric care and for severe mentally defective and epileptic patients. There is one hospital for the care of a limited number of children with serious emotional disturbances who require more care, treatment, and supervision than is possible in an out-patient clinic. In addition, the Branch supervises patients cared for in private boarding homes and inspects private mental institutions. Consultant psychiatrists serve as directors of a number of full-time community mental health clinics located usually in general hospitals.⁶ There are also several travelling mental health clinics,⁷ out-patient departments at Ontario Hospitals, day-care centres, child guidance clinics, and a special

¹The Ontario Hospital Services Commission is directing its hospital planning towards a regional pattern of physical rehabilitation services.

²See Chapter IV, pp. 69-73.

³See also pp. 65-68, for a general discussion of voluntary health agencies.

⁴See Appendix II, pp. 255-261, and Appendix III, pp. 290-297.

⁵For details on the mental health services in the communities studied, reference should be made to Appendixes I-IV, pp. 173-317.

⁶For example, the clinic at the Peterborough Civic Hospital. See Appendix I, p. 193.

⁷For example, the travelling clinic from the Ontario Hospital in North Bay to Kirkland Lake. See Appendix III, p. 279.

forensic clinic. In all, there were 24 Health Department clinics serving 43 communities in February 1963.¹

In addition to facilities provided by the Ontario Department of Health, there are 13 clinics operated by some local health departments and by voluntary agencies in some municipalities.² Public health nurses from the local health department are posted in some Ontario Hospitals to provide valuable liaison with other community services. Others provide a home follow-up service in some communities.

More and more general hospitals in larger urban centres are establishing psychiatric sections to provide short-term psychiatric in-patient care and in some cases out-patient care.

Some school authorities,³ especially those of larger cities, provide mental health consultant services for the school age group. This may be a service provided directly by the board of education⁴ or by arrangement with local mental health clinics under public health or voluntary auspices.

In the large cities there is great pressure for increased community diagnostic and short-term treatment facilities. In the Toronto area, for example, these are developing in larger general hospitals, as an extension of the service of Ontario Hospitals, and through mental health clinics of a diagnostic and out-patient type, under local public health auspices or sometimes voluntary auspices. Public health nurses located in the two Ontario Hospitals in the area are providing liaison with other community services. Several area municipalities offer follow-up, public health nursing visits to homes.

In rural areas and smaller communities, local mental health services are either limited or non-existent. In the Timiskaming District,⁵ the only mental health service available until recently has been by referral to the Ontario Hospital in North Bay. Because of the distance and the cost involved only the most acute cases were sent. This meant that public health nurses, family doctors, teachers, clergymen, Children's Aid Society staff, and other people were attempting to cope with borderline and minor illness cases. The problem was raised by almost everyone interviewed as a serious one because they were aware of their limitations in handling such cases. A travelling monthly mental health clinic was started in November of 1962 on a trial basis. But, it is only to be a referral centre and will not be able to deal with other than relatively serious cases.

In Huron County there were no local mental health facilities until the new Ontario Hospital was opened in January 1963.⁶ Serious cases have been referred to the Ontario Hospital in London. There has been some follow-up from the Ontario Hospital by a staff team who visited the area regularly. However, they were able to look after major problems only. As in the case of Timiskaming, many of those interviewed expressed grave concern that they were being forced to look after problems which they feel inadequate to cope with.

It is difficult to determine the best pattern of services for attacking the many problems of mental health and to evaluate the actual worth of varying approaches presently being tried, such as travelling diagnostic clinics for rural

¹As reported in *The Globe and Mail*, Toronto, February 27, 1963.

²As reported in *The Globe and Mail*, Toronto, February 22, 1963.

³See also p. 28.

⁴For example, Board of Education, City of Toronto. See Appendix IV, p. 313.

⁵See Appendix III, p. 279.

⁶See Appendix II, p. 249.

and smaller urban communities. More extensive and intensive pilot studies which can be carefully evaluated are needed in our view before any final conclusions can be reached.

Whatever final pattern of services finally emerges, at this point, it is our general opinion that a regional organization of all organized health services, including mental care services, would allow the best use of scarce personnel and facilities in both urban and rural areas. The mental health programme should be integrated with the Ontario Mental Hospitals system but also it should be closely integrated with psychiatric sections in larger urban hospitals and rural regional base hospitals, and with the community mental health services provided by local health departments, rehabilitation programmes, school programmes, and social counselling agencies, through a regional health services organization.¹

CARE OF THE AGED²

A wide variety of health and welfare services for older people are available under government and non-government programmes in Ontario. Many of these services are for the population in general but some are specifically designed for older people. The care of the aged is a field which cannot be clearly divided between health services and welfare services, since many of the programmes contain elements of both. Therefore, no attempt will be made to divide services but rather the interrelationship of all of the services in affecting the well-being of older people will be emphasized.

The Ontario Society on Aging has divided existing services and facilities into five general categories,³ as follows:

1. *Income maintenance*.—A variety of programmes of financial support and assistance are available under federal and provincial legislation for older people who meet the specific eligibility requirements. These include the Old Age Security Act,⁴ the Old Age Assistance Act,⁵ the General Welfare Assistance Act,⁶ the Unemployment Assistance Act,⁷ the War Veterans Allowance Act,⁸ the Dis-

¹See Chapter IV, pp. 69-73.

²For details on services for the aged in the communities studied, reference should be made to Appendixes I-IV, pp. 173-317.

³A *Guide to Legislation and Services Related to the Well-being of Older People in Ontario* (Toronto: Ontario Society on Aging, 1962) is the source for the summary presented in this section of the study. Anyone wishing detailed information on any specific piece of legislation or about any specific service should consult the Guide and other detailed sources.

⁴A monthly pension of \$65.00 available to people of 70 years of age or more who meet certain residence requirements. Paid by the Dominion Government.

⁵Assistance payments of up to \$65.00 per month to people between 65 and 69 years of age who qualify under a means test. Administered provincially and financed jointly by the Dominion and the Province.

⁶Assistance payments based on a means test to people who do not qualify for financial help under other programmes. Administered by the municipalities and financed 50 per cent by the Dominion, 30 per cent by the Province, and 20 per cent by the municipality. Assistance is also provided to needy people as determined by a means test for care in registered nursing homes, post sanatorium maintenance, transportation for therapy, certain rehabilitation services, incapacitation allowances, hostel accommodation, and emergency dental care. Supplements of up to \$20.00 per month may be made by a municipality for those on various government assistance programmes for the costs of shelter or other extraordinary costs. The supplements are also shareable. The use of the supplementary assistance provisions is permissive and varies widely among the municipalities.

⁷The Dominion will pay 50 per cent of provincial unemployment assistance costs.

⁸Allowances on a means test basis are payable by the Dominion to Canadian, Commonwealth, and Allied veterans at age 60 years who lived in Canada when they enlisted or who meet certain residence requirements. Female veterans and widows may receive benefits from age 55 years. Age limits are lowered under special medical and economic circumstances. Additional assistance payments are available in special cases.

abled Persons Allowances Act,¹ the Blind Persons Allowances Act,² the Pensions Act,³ the Workmen's Compensation Act,⁴ and the Income Tax Act.⁵ In addition, the National Employment Service offers special counselling and job placement assistance to people in middle and older age groups who request these, and the legal profession in Ontario provides free legal assistance in most civil and criminal matters to people whose yearly earnings are below a set level.⁶

2. *Health and medical care.*—Services available include those under the Ontario Medical Welfare Plan,⁷ the Hospital Services Commission Act,⁸ the Homemakers and Nurses Services Act,⁹ the Vocational Rehabilitation of Disabled Persons Act and the Rehabilitation Services Act,¹⁰ the General Welfare Assistance Act,¹¹ the Prepaid Hospital and Medical Services Act¹² for incorporating non-profit prepayment plans,¹³ the Public Health Act,¹⁴ the Pilot Home Care Project in the

¹ Assistance payments of up to \$65.00 per month to totally and permanently disabled adults who qualify under a means test. The programme is administered provincially and financed jointly by the Dominion and the Province.

² Assistance payments of up to \$65.00 per month to those who qualify under the definition of blindness and a means test. Remedial eye treatment is provided for those who might benefit from it. If successful, the allowance would not be paid after three months. The programme is administered provincially and financed jointly by the Dominion and the Province.

³ Pensions paid by the Dominion to members of Canada's Armed Forces with a disability at the time of retirement or discharges. Pensions are also payable to dependents of deceased veterans.

⁴ Compensation for temporary income loss, medical expenses, and permanent disability pensions are paid to workmen who are injured or become ill as a result of their work. There are also dependents', survivors', and certain other special benefits administered by the Workmen's Compensation Board of Ontario and financed from a graded assessment on industry.

⁵ A taxpayer may deduct \$500.00 from taxable income for Dominion income tax purposes for the year in which he becomes 65 years of age and for subsequent years. Up to \$500.00 may be deducted by a taxpayer for a totally dependent parent or grandparent because of mental or physical infirmity.

⁶ \$1,200.00 per year for single people and \$1,800.00 per year for couples.

⁷ Eligible older people include those receiving Old Age Assistance, General Welfare Assistance, Blind and Disabled Persons' Allowances, Rehabilitation Services Allowance, Mothers' Allowance, and, subject to a means test, Old Age Security. Funds are paid by the Province into the Plan, established through the Ontario Medical Association. Benefits include home and office calls, and emergency medication. Glasses, dentures, hearing aids, and medical services in hospital or as an out-patient are not covered. Separate provincial arrangements provide payment for agreed medical services in a nursing home or home for the aged.

⁸ Those receiving categorical assistance allowances have their premiums in the Ontario Hospital Insurance Plan paid by the Province. For those on general welfare assistance, the municipality of residence is responsible either for paying their premiums or for paying their actual costs of hospitalization at a set *per diem* rate.

⁹ Any municipality may provide directly nursing and/or homemaking services on visiting or part-time bases for elderly, handicapped, ill, or convalescent people so they may remain at home or return from a hospital or other institution or may purchase these services from voluntary organizations. For needy people, as determined under the terms of the legislation, the Province will reimburse a municipality up to a set maximum amount.

¹⁰ The costs of any restorative, vocational, social or prosthetic services, to disabled people capable of vocational usefulness from re-training are shared jointly between the Dominion and the Province under these acts. The programme is administered by the Province.

¹¹ Provisions are available under the General Welfare Assistance Act for re-training unemployed or unemployable people capable of benefiting from such re-training and who are eligible under a means test. The programme is administered provincially and jointly financed by the Province and the municipality of residence. Prosthetic appliances are included.

¹² Companies or corporations may incorporate to provide prepayment for personal health services on a non-profit basis to subscribers.

¹³ Such as Physicians Services Incorporated, Windsor Medical Services, Associated Medical Services Incorporated, and several co-operative prepayment plans.

¹⁴ See a description of the services provided on pp. 11-31. Aside from general public health services, such as public health nursing visits, a few local health departments are experimenting with special services for the aged.

City of Toronto,¹ the programmes of the visiting nursing organizations² and of a number of voluntary health agencies which provide services for those with certain diseases or categories of disease.³

3. *Independent accommodation.*—Various types of housing arrangements are assisted under federal and provincial legislation including the National Housing Act,⁴ the Housing Development Act,⁵ the Elderly Persons Housing Aid Act,⁶ the Homes for the Aged Act,⁷ and the Income Tax Act.⁸

4. *Institutional accommodation.*—Institutional accommodation and care is made available and assisted under various provincial acts, including the Homes for the Aged Act,⁹ the Charitable Institutions Act,¹⁰ the General Welfare Assistance Act,¹¹ the Municipal Act,¹² and the Public Health Act.¹³ The Dominion

¹A wide variety of medically prescribed home care services for acute, convalescent, chronic, and terminal patients are provided through official and voluntary health, welfare, and social agencies; administered by the Department of Health in co-operation with the doctors, agencies, and hospitals; financed under a National Health Grant. Recently, two hospital programmes, the Toronto Western and Mount Sinai, have become associated with it. They are financed by the Ontario Hospital Services Commission. See pp. 63-64.

²Visiting nursing services on a sliding fee scale are provided by the Victorian Order of Nurses and the St. Elizabeth Nursing Association. These are financed by public appeals, government payments, and private fees.

³For example, the Canadian Cancer Society, the Canadian Arthritis and Rheumatism Society, the Canadian National Institute for the Blind, and so on.

⁴Under this Act the federal Central Housing and Mortgage Corporation may make available long-term, low-interest loans to limited dividend companies for low-rental housing projects. These may either construct new units or acquire and convert existing ones. Church and voluntary groups and private citizens groups may form limited dividend companies which also may include municipal representatives. Under other sections loans by banks or other agencies for home improvements or extensions may be insured by the Corporation provided that the home owner meets certain requirements. A further section permits the Corporation jointly with a province to acquire land and construct housing projects for sale or rent, on a 75:25 per cent sharing basis for costs and profits. Projects may either have a fixed rental which covers operating costs and will recover the capital investments or be subsidized with the deficits shared on the 75:25 per cent basis. Municipalities desiring such a project must submit proposals through the Province.

⁵This Ontario Act permits municipalities to participate in projects under the joint dominion-provincial arrangement just described and to assist in securing funds and land.

⁶This Ontario Act makes capital grants available to limited dividend housing companies for the construction and equipping of low-rental housing for elderly people.

⁷The cost of maintenance in an approved private boarding home of a person eligible for admission to a Home for the Aged may be shared on an agreed basis with the municipality of residence in lieu of admission to a Home.

⁸Corporations constituted solely for providing low-cost housing for the aged are income tax exempt if none of the income is paid to any proprietor or member of the corporation. Donations to such corporations are also exempt from income tax.

⁹Municipalities are required to provide care in a home for people who are over 60 years of age and incapable of supporting or caring properly for themselves, who are over 60 years of age and mentally incompetent but ineligible for admission to a mental hospital, who are confined to bed but do not require hospital care, and who are under 60 years of age but cannot be cared for adequately elsewhere. A municipality may either establish its own home, establish a joint home with another municipality, or enter into an agreement with another municipality to admit residents to its home. The Province meets 50 per cent of construction, extension, or renovation costs, including equipment and furnishings and also pays 70 per cent of net operating and maintenance costs.

¹⁰Capital grants of \$2,500.00 per bed or 50 per cent of construction costs, whichever is the lesser amount, and grants for acquiring buildings are provided by the Province, as well as 75 per cent of the maintenance costs of needy people up to a set daily maximum, to charitable organizations providing homes for older people. Assistance through capital grants is also available for hostels for transient and homeless people, provided the municipality makes a payment of at least 20 per cent of the cost.

¹¹The Province will share with a municipality the cost of care in a municipally licensed nursing home for eligible needy people, either on the basis of 80 per cent of the municipal grant or \$80.00 per month, whichever is the lesser amount.

¹²The Act permits municipalities to make grants to charitable institutions, to set standards for dwellings and lodging houses, and to authorize inspection of sanitary conditions and fire hazards.

¹³A municipal department has the duty to inspect public and private institutions for sanitary conditions and other requirements under the Act.

Excise Tax Act refunds the federal sales tax on purchases by eligible institutions of construction materials and goods used in operating the institutions.

5. *Recreation and education.*—The Province may make a grant, under the Community Centres Act, towards the construction costs of a community centre,¹ which may be used as a club or centre for older people. The Department of Education Act enables the Minister to make regulations on adult education, camping, and recreation. Grants are made to boards of education for night school classes. Correspondence, academic and vocational courses are offered by the Department. Advisory services to those working with older people and recreational activity courses are available. The Elderly Persons Social and Recreational Centres Act of 1961-62 enables the Province to make grants to an approved corporation for erecting, altering, extending, or acquiring a building for a centre for older people. The amount may not exceed 30 per cent of the cost to the corporation and is paid only if the municipality pays at least 20 per cent of the cost. The Canadian Red Cross Society Senior Citizens Committee offers courses for groups wishing to establish community information services and friendly visiting services.

In every community visited during the field studies, the care of the aged was considered by most people interviewed as one of the most difficult problems they were facing.² In spite of the multiplicity of legislation, at present the difficulties in finding suitable answers for the problems of many individual older people are almost insurmountable because of a lack of co-ordination in planning and providing services. In the larger cities, a number of official, church, and voluntary agencies were found to be providing a variety of health, welfare, and recreation services.³ In rural areas and small urban centres, except for the county home, some visiting nursing by the health unit or a voluntary group, and an occasional home or housing project under church or lay voluntary auspices, there was usually found to be little formal service.⁴ Among the needs of older people noted and mentioned during the field studies are homemaking service, coverage for the costs of drugs, and for dentures, glasses, hearing aids, and other appliances, friendly visiting, mobile libraries, other convenient recreation facilities, and the provision of assistance in obtaining hot meals.

Voluntary Senior Citizens Councils in Ontario are doing a valuable job of co-ordinating information and voluntary activities in a number of municipalities.

It is suggested that a regional health services organization⁵ could draw together the official services of the hospitals, the public health department, rehabilitation programmes, and home care services, which are all concerned with the health of older people. In turn, these need to be co-ordinated with some type of regional welfare authority, either on an integrated health and welfare basis or in close liaison. This integrated administrative body or the separate health and welfare regional organizations on an agreed joint basis would be responsible for co-ordinating official services and facilities, such as the hospitals,⁶ chronic care

¹To a maximum of \$5,000.00 or 25 per cent of construction costs.

²See Appendix I, p. 202, Appendix II, p. 254, Appendix III, p. 290, and Appendix IV, p. 316.

³See Appendix I, pp. 197-202, and Appendix IV, pp. 316-317.

⁴See Appendix II, pp. 252-254, Appendix III, pp. 289-290.

⁵See Chapter IV, pp. 69-73.

⁶The use of day and night hospital concepts, as seen in Europe, is suggested in addition to standard in-patient arrangements.

institutions, home care services,¹ nursing homes, rehabilitation services, and varied living arrangements and facilities for well older people.² There would need to be close liaison with the voluntary senior citizens councils, with private homes for elderly people under religious and other voluntary auspices, and with other voluntary services. Only on such a regional and co-ordinated basis will it be possible, in our view, to overcome the general lack of awareness of the complexity of the problems of the aged, of the interdependency of health, housing, economic, and recreational factors in solving them, and of a need for a variety of services and facilities to meet the varying requirements of older people.

HOME CARE

Visiting nursing services are provided in most larger urban communities and some smaller urban centres by the Victorian Order of Nurses and in a few cities also by the St. Elizabeth Visiting Nurses' Association.³ Both provide care under the direction of a physician only.⁴ A number of urban communities also have homemaking services, provided under the aegis of the Ontario Division of the Red Cross or by separate voluntary agencies. The homemaking agencies show variation from community to community in the types of client they will serve, largely as a result of limitations in funds and staff numbers. Thus, some serve only homes with small children where the mother is ill or in hospital,⁵ whereas other homemaking agencies will also provide service to older people. The homemaking agencies also limit the length of time over which they will give service. If longer term arrangements are needed, then either some private arrangement or institutional arrangement has to be found for the client.

The visiting nursing and homemaking agencies are financed from several sources, including united appeal or separate campaign funds, fees from clients,⁶ and government grants.⁷ Proprietary homemaking agencies exist in most of the cities but these services are too expensive for many people.⁸

¹Including male home helps and other personnel for older men with certain types of medical problems.

²Small homes in larger villages and towns, flats in apartments, and boarding homes rather than one large county home. In the cities, district homes and flats are suggested rather than large, semi-isolated facilities and institutions. Financial assistance in installing handrails, toilet bars and ramps, etc., is also a part of the housing need.

³For example, both organizations provide services in Toronto. The V.O.N. also provides services in Peterborough and in Teck Township (Kirkland Lake) in the communities studied on our field visits. See Appendix IV, p. 316, Appendix I, p. 185, and Appendix III, p. 278.

⁴An initial assessment visit will be made on request of a family but subsequent visits if indicated will be made only if the patient is under medical supervision. The visiting nurse works under the physician's direction and keeps him fully informed about all visits.

⁵For example, the Visiting Homemakers Association in the City of Toronto. A pilot study in part of the city supported by a grant indicated a considerable need for service to older people. However, no permanent financing arrangement for such an extension of service has as yet been found. See Appendix IV, p. 316.

⁶On a sliding scale according to ability to pay.

⁷Some municipalities make direct lump grants to the agencies in return for service to those residents unable to pay for care. Under the Homemakers and Nurses Services Act of 1959 a municipal council may pass an enabling by-law under which it either employs directly nurses or homemakers or both to provide home care services or under which it enters into an agreement with voluntary agencies to provide the services. Those receiving service are required to pay for it to the extent that their financial circumstances permit, as outlined in the regulations under the Act. A municipality may pay the costs in part or in full for those who cannot pay for their care. The Province will reimburse such a municipality 50 per cent of the amount so paid or \$4.00 per day, whichever is the lesser, for homemaking services provided to a person. In the case of a nursing visit to a person who meets the qualifications under the Act, the Province will reimburse such a municipality 50 per cent of the amount so paid for each visit or \$1.25 per visit, whichever is the lesser. The Act is permissive and only some municipalities have passed the enabling by-law.

⁸For example, see Appendix I, p. 215. There are several proprietary homemaking agencies in Metropolitan Toronto.

Larger urban centres may also have voluntary agencies which provide home physiotherapy on a visiting basis.¹ These are financed by a sliding fee schedule based on the patient's ability to pay and from general agency revenues received from united appeal or separate campaign funds and sometimes from provincial and/or municipal grants.

The only comprehensive organized home care programme in Ontario is the Pilot Home Care Programme in the City of Toronto which began in February 1958.² This is administered under the city Department of Health with the assistance of an advisory committee and is supported through a national health grant. It is a community-based programme³ designed to co-ordinate existing official and voluntary agency services for patients in their own homes. Where considered medically suitable, services are provided to patients in the acute, convalescent, chronic, and terminal stages of illness as an alternative to hospital care. Among the services provided at the request of the physician caring for the patient, are public health nursing visits, visiting nursing visits, social casework services, public welfare department worker visits, homemaking services, transportation to clinics and other prescribed services, appliances and equipment, other medical supplies, and drugs.

In September 1961, an extension of services was begun to determine the value of discharging selected patients earlier than otherwise from hospital and of completing treatment at home. Patients are selected from the New Mount Sinai and Toronto Western hospitals and this extension of service is largely financed by a national health grant with supplementary grants from the City and the Ontario Hospital Services Commission. Up to 60 days of post-hospital care and if necessary an added period are provided.

A recent article⁴ on the programme concludes that organized home care is suitable as an adjunct to in-hospital, out-patient, or nursing home care for selected patients and that there is a sufficient caseload to support a permanent programme in the Toronto area. Because of the numbers of hospitals and agencies involved a community-based programme is recommended rather than a purely hospital-based one. It is also pointed out that some suitable permanent financing arrangements will be required.

An organized home care programme was felt to be one of the services needed in the urban communities visited, Metropolitan Toronto,⁵ Peterborough,⁶ and Kirkland Lake,⁷ because of the numbers of residents living alone in flats and rooms, who had no close relatives or friends who could help them and the numbers of older people, especially living with some other family member who needed skilled assistance and some relief in the work of caring for them.

Home care services, except for some visiting nursing service by the public health nurses, are rarely available either through official or voluntary agencies, in rural areas and smaller urban communities in Ontario.⁸ Private arrangements

¹For example, the Canadian Arthritis and Rheumatism Society in Peterborough and Toronto and the Toronto Rehabilitation Centre. See Appendix I, p. 204, for a description of the Peterborough C.A.R.S. service.

²For details see Barter, Marion I., "The Pilot Home Care Program of Toronto", *Canadian Journal of Public Health*, Vol. 54 (February 1963), p. 55.

³Representative of the professional, hospital, and agency groups concerned.

⁴Barter, *loc. cit.*

⁵See Appendix IV, p. 316.

⁶See Appendix I, p. 202.

⁷See Appendix III, p. 290.

⁸Usually limited to assessment and emergency care visits. Occasionally, as in the Durham-Northumberland Health Unit, more extensive service is provided if needed.

must be made for housekeeping and any home nursing required. In the areas visited of these types, it was indicated that family, neighbours, and married nurses could usually help out on a short-term basis but that longer term care presented some problems. There is also the consideration that, in winter in many rural areas and at all seasons where the population of one area is thinly scattered it may be more economic in terms of personnel to move patients to nursing home, hospital, or other institutional facilities.

A recent study by the Health Unit in a southern and chiefly rural county in Ontario, Wellington County,¹ indicated an extensive unmet need for visiting nursing service and homemaking service.² Moreover, an estimated 100 registered nurses³ in the area were found to be interested in working in such a programme on a part-time basis.

It is suggested that an organized home care programme should be established on a regional basis by a regional health services administration or, where it exists, a regional health and welfare services administration. It should be integrated with the public health services, hospitals and other organized programmes.⁴ The home care programme should be closely co-ordinated with the regional welfare organization and services, since certain home services, such as homemaking and nutritional counselling, are needed by families for other than sickness reasons. The extent and variety of services provided should be determined on the basis of an assessment of the actual need in each region.

Purchase of services could be made on a cost basis from voluntary agencies in larger communities provided that the agencies were prepared to meet acceptable standards of care. In rural areas and smaller urban communities, where there are either limited or no voluntary agencies providing home care services, the regional health services administrative body should provide the services directly. There would also have to be some form of economic coverage which would encourage people to use home care services, if suitable for their care, rather than entering a hospital simply because they happen to be insured under the Ontario Hospital Insurance Plan.

AMBULANCE SERVICE⁵

One of the problems in rural and small urban communities especially was found to be the provision of ambulance service. It requires a fairly large population centre to make either a private or public ambulance service economic on a full-time basis and to employ personnel properly trained in first aid and in the handling of seriously ill or injured people. Some rural and smaller urban municipalities operate an ambulance service or more commonly pay a subsidy to a private operator, usually the local undertaker, for providing service on a part-time basis.

¹Dale, B. T., and Mumby D. M., *A Study of Home Care Needs in Wellington County*. (The Wellington County Board of Health, 1961.) The City of Guelph is not in the Health Unit and was excluded. The Unit in 1961 covered about 45,000 people. There are two towns of about 4,000 and 2,200 people respectively and several smaller communities of 1,000 or fewer people each.

²An estimated 1,600—1,700 visiting nursing situations and over 1,600 homemaking situations in the study year.

³Not otherwise doing regular nursing work and prepared to give some time for this purpose.

⁴See Chapter IV, pp. 69-73.

⁵See also Appendixes I-IV, pp. 173-317.

In rural areas and smaller urban centres, one solution would be to have the ambulance service provided on a regional basis rather than by separate municipalities. The regional health services administration¹ could either operate it directly or subsidize a full-time private operator for providing service at reasonable cost to all and free to those unable to pay. This would permit the most economic use of equipment, the provision of trained staff, and would make good full-time service available to all residents, hospitals, and other institutions. For isolated areas, a regionally based, provincially operated, air ambulance service is suggested.

In the larger communities, there are usually some private ambulance services, but these may be too few to meet the demand at all hours and seasons and in all parts of a large community. Moreover, service is relatively expensive. In these communities, the regional health services body² could operate an ambulance service, as does the City of Toronto Health Department. Financial arrangements should be made, where there is no public ambulance service, to assure that those unable to pay receive necessary service and that all the public have service available at reasonable cost.

OFFICIAL WELFARE SERVICES AND VOLUNTARY HEALTH AND SOCIAL AGENCY SERVICES³

The Ontario Department of Public Welfare has a number of regional offices in Ontario whose concern is with the administration of the allowances, provided by the Dominion and the Province jointly or by the Province alone, for people in specific categories of need, with the general oversight of the municipal welfare departments in the area, and with general welfare assistance in unorganized areas.

Municipal welfare authorities are largely concerned with administering general welfare assistance, including in specific instances additional permissive payments for fuel, rent, drugs, etc., and with helping to administer certain applications, such as those for homes for the aged. The supplementary payments vary in extent from municipality to municipality and, in general, are provided chiefly in large urban communities. In addition, some communities have passed a by-law enabling them to use provincial legislation for the payment of visiting nursing services and in a very few instances for homemaking services for those receiving categorical allowances and on general welfare assistance.⁴ Some municipal departments, again chiefly urban ones, have limited funds for meeting emergency problems not otherwise covered. The welfare department except in a few large municipalities, such as Toronto, provides no trained counselling or services other than financial assistance as required by legislation.⁵ The welfare officers as a rule are not qualified social workers. The aim sometimes appears to be to keep welfare assistance as low as possible rather than to meet the actual needs people have.

Thus, among the direct help related to health which voluntary welfare groups, church groups, and service clubs are trying to provide are necessary drugs, prostheses, dentures, glasses, dental care for children, home nursing equipment, and special dietary supplements. Some voluntary groups have set

¹See Chapter IV, pp. 69-73.

²*Ibid.*

³For details on patterns in the communities studied, see Appendixes I-IV, pp. 173-317.

⁴See footnote 9, p. 59.

⁵See Appendix I, pp. 195-196, Appendix II, pp. 251-252, and Appendix III, p. 289.

policies about the sorts of services and assistance they will provide. Others consider requests on an individual basis. Clients seek help themselves or are referred by public health nurses, doctors, clergy and others.

Cases are often referred to the health department or unit for help. In turn, the staff members must seek a group who will help with the particular problem. In areas where the municipal services are limited, a good deal of time is spent on such activities by the health department staff. This "hat in hand" work and the time involved were sources of complaint in the areas visited. In some of the municipalities of Metropolitan Toronto and in Teck Township,¹ the municipal welfare authorities do a good deal of this work and try to meet the needs not covered by legislation.

Organized voluntary health agencies, outside the larger urban centres, were found to be relatively few in number.² Most of those with active service programmes, in addition to local public education and fund raising, are branches of provincial or national bodies. Their relations to these senior bodies vary from almost total to limited autonomy. Specific clinic services, visiting staff services, or special services, such as blood bank supplies, are, as a rule, arranged and staffed from provincial or regional offices of the agencies.³ Local volunteer groups for these agencies are concerned chiefly with assisting at clinics, raising money to assist in paying the salaries of any staff working in the area, providing personal needs for those with a particular disease, helping with the costs of transportation to and accommodation in urban centres for those needing special treatment, and providing home nursing equipment, dressings, and so on. As such they fulfil varied and valuable functions. The chief problem is that only some of these groups and, hence, services exist in any but the largest communities.

Even in a city of the size of Peterborough,⁴ services were found to be limited in number and extent. On the other hand, in large urban communities, like Metropolitan Toronto,⁵ there are a multiplicity of agencies attempting to meet different kinds of health service need. Problems of co-ordination and even some overlapping of interest were found and reported to exist. Some health agencies in these large communities provide extensive direct services, for example, home nursing, home physiotherapy, rehabilitation centres, counselling, and recreational facilities.

The health-related problems raised by the official welfare officers and the voluntary health and social service agencies varied from community to community, even within one area, such as Metropolitan Toronto or the District of Timiskaming. The variation could be related largely to the extent of assistance provided by municipal welfare departments and in turn to the degree to which voluntary agencies, church groups, and service clubs attempt to provide services not otherwise provided.

In rural and smaller urban areas, among the problems commonly mentioned were limited municipal welfare assistance and services, difficulties in getting interested and active branch officers, fund raising, and the virtual absence of

¹See Appendix III, p. 289.

²See Appendix II, p. 255, and Appendix III, p. 290.

³For example, the Ontario Society for Crippled Children, the Rehabilitation Foundation for Poliomyelitis and the Orthopaedically Disabled, the Canadian National Institute for the Blind, the Ontario Division of the Canadian Red Cross, and the Ontario Cancer Society, and the Ontario Tuberculosis Association.

⁴See Appendix I, pp. 202-203.

⁵See Appendix IV, p. 317.

trained social counselling services. This last was a concern of almost every official and voluntary agency visited. In two of the areas, the Children's Aid Society is the only experienced counselling source available and its staff members have limited time for such additional responsibilities.¹ Even in Peterborough only one additional counselling agency with trained staff exists.² Thus, public health nurses, teachers, and others are forced to cope with these problems as best they can and at considerable loss of time from the work they are trained to do.

In large cities, such as Toronto and to some extent in Peterborough, the problems mentioned were related to overlapping and duplication of service in some areas of need, gaps in others, staff shortages, and to insufficient co-ordination in the use of special staff and facilities and in the provision of services.³ Metropolitan Toronto has a Metropolitan Social Planning Council, a voluntary organization, which endeavours to bring the official and voluntary agencies, professional groups, and interested citizens together for purposes of planning and co-operation in providing services. Expert consultants are retained and studies are carried out.⁴ In turn the central body may break down some of its operations on an area basis or problem basis, as does the one in Metropolitan Toronto by means of area councils and special sections, such as health and aging. In contrast, in Peterborough, the interested senior staff members of some of the official and voluntary agencies meet from time to time on an informal basis only, largely for social purposes and to get to know one another. No unanimity of view was found on the question of forming a more formal though voluntary planning and co-ordinating structure.⁵

Almost all agencies visited in the study communities had financial problems. A few, such as the County Tuberculosis Associations and the Ontario Society for Crippled Children, have found highly successful fund-raising techniques.⁶ However, most say they need more money than they have available. Funds are obtained from a combination of joint united appeal or community funds and increasingly from provincial and municipal lump grants or purchase of specific services. Some charge service fees to clients who are able to pay. United campaigns as a source of revenue appear to have limitations beyond which it seems difficult to get increased public donations. In fact in some cases, for example, some agencies not only have been unable to extend services proven to be necessary, but have even had to cut back on services.⁷

This situation raises the question as to the place which voluntary giving as opposed to tax funds should play in providing services now largely provided by voluntary health and welfare agencies. It is our view that where services are

¹See Appendix II, p. 256. and Appendix III, p. 296.

²See Appendix I, p. 208.

³See Appendix IV, p. 317. and Appendix I, pp. 217-218.

⁴For example, the extensive Needs and Resources Study which has taken several years, involved over 100 agencies, and has used a number of technical and expert committees and workshops in carrying out its purposes. *A Study of the Needs and Resources for Community-supported Welfare, Health, and Recreation Services in Metropolitan Toronto*. (Toronto: Social Planning Council of Metropolitan Toronto, 1963.) See Appendix IV, p. 317.

⁵See Appendix I, p. 208.

⁶The Christmas and Easter Seal Campaigns respectively. Indeed, some suggestion was made that some agencies may be raising more money than they can spend for present needs of service in their fields.

⁷For example, in *The Globe and Mail*, Toronto, March 1, 1963, it is reported the United Community Fund of Greater Toronto has had to cut 1963 allocations as compared to 1962 for 16 local agencies and three national bodies, including the four family service associations, the Victorian Order of Nurses, and the Visiting Homemakers Association. This has already been reported as resulting in reductions in staff and services and in longer waiting periods for obtaining counselling.

regarded as basic for the community as a whole or for a large segment of it, they should be financed from public funds. Examples would be visiting nursing, homemaker service, and ambulance service. The services could be provided either by official agencies direct or by the purchase of the services at cost and at acceptable standards to the community from existing voluntary agencies. Fees could still be charged to those able to meet all or part of the cost of the service. This change would permit agencies in the counselling field in particular to increase their services to meet the increasing volume of work with which their present staffing and revenues cannot cope.

It is often difficult to say whether the needs of a particular person or family are basically health, welfare, or social counselling, because in many cases problems of all three types are involved. Such cases provide problems in jurisdictional responsibility and in liaison. Deficiencies in public welfare benefits were frequently pointed out as being at the root of health problems for those from low-income and indigent families, for example, drug costs, preventive dental care for children, and dentures, glasses, hearing aids, etc., for the elderly. In turn, unmet health needs were indicated as often leading to economic dependency. Though detailed consideration of the question is not within the specific terms of this study, it is quite clear that an immediate intensive review and revision of existing public welfare administrative patterns and benefits should be undertaken.

Some of those interviewed suggested combined local health and welfare units. In theory this appears to be a desirable long-term development. However, its success will depend upon a change in both provincial and local welfare policy and practice in Ontario and on the greater availability of qualified staff. Common province-wide policies and a regional pattern of welfare administration, as in the health service field, seem to be the first steps required. It is not clear whether the further combination of health and welfare services under one administrative entity is practical in Ontario. Further study is recommended through experimentation with a joint administrative organization in selected urban and rural areas.

THE MAIN SUGGESTION—A REGIONAL ADMINISTRATIVE PATTERN FOR THE ORGANIZED COMMUNITY HEALTH SERVICES

Scientific, social, and economic changes are making the traditional pattern of separately developed and administered community health services less and less efficient. Circumstances have combined to create a rapid proliferation of health services of ever increasing complexity. The resultant overlapping of service in some areas, gaps in services in other areas, and uneconomic use of skilled personnel and complex facilities are hampering the ultimate objective of providing a balanced pattern of modern community health services which work together effectively. Segregated community health service planning and administration should be ended.

Therefore, the main suggestion is for a regional administrative pattern of all organized community health services in Ontario.

GENERAL STRUCTURE

The regional health services organization would result from a realignment and gathering together of the community-based health services. None would be "taken over" by another but all would be part of a larger administrative body.

It is suggested that the two chief components be the hospitals and the public health services and that the other components be the organized rehabilitation, mental health, home care, and ambulance services and the health services for the aged.¹

Such a co-ordinated network of basic supportive programmes and facilities would assist the practising physicians and dentists in providing care for their patients.

The precise delineation of regions should take account of existing formal and informal regional patterns for certain services, as well as factors of geography and population. Therefore, the area and population served would vary from region to region. For example, it is suggested that Metropolitan Toronto be one region, whereas in predominantly rural areas, several existing counties might be included in a single region. It seems obvious that in northern Ontario regions will be larger in area and smaller in population than in southern Ontario.

A third major component, when circumstances permit, should be the official social welfare services. The administrative structure would then be that of a regional health and social welfare organization.

¹Specific service and programme proposals are summarized in Chapter V, pp. 75-87.

Extensive changes in welfare policies and services are necessary before this additional step could be introduced. Detailed study of the best way to effect this step should be carried out, in order to ensure that neither health nor welfare would be overshadowed by the inclusion of the other.

ADMINISTRATION

Provincial

Based on general enabling legislation, the provincial public health and hospital authorities should jointly establish general policies, broad uniform standards, and the basic programmes to be provided.

Details of local policy and programme would be a responsibility of regional boards.

Further, it is our view that the Ontario Department of Public Health and the Ontario Hospital Services Commission either should be combined in a Health and Hospital Services Department under the Minister of Health or a statutory board representing both should be formed under the Minister of Health to carry out provincial obligations.

Regional

It is desirable to retain a sense of local interest and as much local autonomy for individual programmes as is compatible with the efficient provision of service.

It is, therefore, suggested that there be for each region a Regional Health Services Board, representative of the elected councils of the municipalities in the region, of the professional groups providing health services, and of the general public.

The municipal representatives could be selected on a rotating basis by the municipalities. A proportion of the health service representatives could be nominated by such bodies as local medical and dental societies and appointed by the Minister of Health. Others could be directly appointed by the Minister to add people with special technical knowledge and experience to the Board. The public representatives could be nominated by groups, such as business, labour, farmers, women's institutes, educational groups, and voluntary health groups, and be appointed by the Minister. Board members should receive a suitable *per diem* payment for time spent on Board duties, in addition to coverage of any expenses incurred.

The Regional Board would replace local boards of health and any other official agency boards, except those of hospitals and other institutions. Local hospitals and institutions would continue under their existing ownership, whether lay voluntary, religious, or local government, and their governing boards would continue to be responsible for the direct internal administration of their respective institutions. However, certain responsibilities of regional importance, such as the planning of extensions and alterations, the distribution and allotment of different kinds of bed, the acquisition of specialized equipment and facilities to be used in common and the retention of specialized professional and technical staff to be shared in common, would be transferred to the Regional Board. General questions of staffing¹ and financing² are dealt with in other sections of this chapter.

¹ See pp. 71-72.

² See pp. 72-73.

STAFFING

Executive Officers

The day-to-day administration will require executive officers with specific preparation for health services administration. Such people at present are of two types, those with special education and training in public health administration and those with special education and training in hospital administration. At present their respective preparations are directed to different types of health service administration. Accordingly, it is suggested that where someone with one type of preparation is selected as the senior executive officer that his deputy be someone with the other type of preparation. Their knowledge and experience would, thus, be complementary. It is our view that if a suitable candidate of either type is available, who in addition is a qualified physician, he should receive preference in the senior appointment.

The chief executive officer and his deputy should be appointed by the Regional Board, subject to approval by the Minister of Health, and be directly responsible to the Regional Board for carrying on the responsibilities assigned to the Board by provincial legislation and regulations and for performing any other duties specified by the Board.

The chief executive officer and the deputy executive officer should not be dismissed by the Regional Board except on proof of negligence or incompetence and with the concurrence of the Minister of Health. If the Minister should feel that an executive officer is not fulfilling his obligations under provincial legislation and regulations, he may indicate the specific details of the situation to the Regional Board and make any suggestions which he wishes. But, the power to recommend dismissal to the Minister should rest with the Regional Board.

It is suggested that basic salaries be set and paid by the Province and that pension arrangements be established on a province-wide, portable basis. This would permit satisfactory, uniform, minimum salaries and pensions. Regional Boards would be free to increase salaries as they wished, with the concurrence of their component municipal councils, as a means of attracting the most competent administrators they can. A portable, provincial pension system would permit mobility of staff, which, under separate regional pension systems would be hindered.

Health services administration can only be as good as are the capacities and competence of the administrators. In the future, the most desirable administrator would be someone with special training in the broader field of health services administration.

Financial support should be given by the Dominion and the provinces to appropriate university bodies, such as the Schools of Hygiene, for developing courses in health services administration for those already in public health and hospital administration and for qualified new recruits to the field.

Other Administrative Staff

Existing hospital and other administrators, trained through the Canadian Hospital Association Extension Course or other acceptable non-university courses and existing experienced administrators without formal training would continue to be needed to assist the senior administrators at regional and at individual institutional and programme levels. They should be given every encouragement for taking additional preparation to extend their knowledge and to become qualified for more senior posts.

It is suggested that other administrative staff be appointed and employed on the same basis as the senior executive officers and that they be directly responsible to the senior officers for the administration of their respective institutions or programmes.

Other Staff

It is suggested that the personnel for specific institutions and programmes be employed and paid directly by the institution or programme concerned, subject to the general budgetary approval of the Regional Board.

The pension arrangements should be established on a portable provincial basis, so that mobility of staff will be possible. Any institution or programme staff member who has been discharged should be able to appeal the decision to the local institution board, if one exists and, in any case, to the Regional Board for final decision.

In rural and northern regions, it is suggested, as outlined in Chapter V, that certain medical and other personnel be retained directly by the Regional Board, on recommendation of the senior executive officer and subject to the concurrence of the Minister of Health.

They would vary in numbers and type with the needs of a region. Moreover, the numbers and type would be altered as sufficient numbers of qualified personnel entered private practice in a region. Their services would be available to the private practitioners as well as to the institutions and programmes operated directly by the Regional Board. Subject to provincially established minimums, payment would be through the Regional Board on a basis agreed on between it and the staff person in question. Pension arrangements should be on a province-wide, portable basis.

It is also suggested, as outlined in Chapter V,¹ that in regions without minimum dental services a dental services programme be established on a similar basis.

FINANCING

Except for large urban regions, institutions and programmes other than those covered under the Ontario Hospital Insurance Plan should be financed on a 70 per cent : 30 per cent basis between the Province and the individual Regional Boards.

The direct revenues of a Regional Board would come largely from an assessment, on an equitable basis, against the component municipal councils. To some extent they could come from any direct fees which a Regional Board may decide to charge for certain services. These direct fees should be designed so as not to deter the use of needed service and, where used, to take account of a person's ability to pay. The decision to charge fees for any specific service and the amounts should have the concurrence of the Minister of Health.

For a region which either consists of a single, large, urban community or which contains a predominantly urban population, it is suggested that the Province share the costs with the Regional Board on a 60 per cent: 40 per cent basis.

¹ See pp. 83-84.

The hospitals would continue to be financed as at present except that budgets would be submitted through the Regional Boards and all provincial payments would be made through the Regional Boards.

It is further suggested that the Dominion Government make available a general grant to the provinces to cover one-half of their operating expenditures for regional programmes, as approved by mutual agreement between the Dominion and a province, but excluding costs covered under the Hospital and Diagnostic Services agreements and under the National Health Grants Programme for specific purposes.

GENERAL RELATIONS WITH VOLUNTARY HEALTH AGENCIES

Where a voluntary health agency is providing a direct health service, which is considered to be a basic community service, depending upon the extent of the existing voluntary agency service and local decision, it is suggested that the Regional Board either take over the service as a direct public responsibility or purchase specific service at cost and at standards acceptable to the Regional Board from the agency concerned.

Where such basic services do not at present exist or where they are only rudimentary, either they should be established by the Regional Board, as available staff and facilities permit, or financial arrangements should be made with a voluntary agency to establish them on an acceptable basis.

GENERAL RELATIONS WITH OFFICIAL WELFARE SERVICES

Close liaison is of great importance because so many services have both health and welfare components.

As previously pointed out,¹ a combined Regional Health and Social Welfare Organization is suggested as a long-term development.

This development will depend upon a prior review of existing public welfare policy, staffing, and services in Ontario, since at present welfare programmes at the municipal level are in general less developed than are health and hospital services.

¹ See p. 69.

SUMMARY OF SUGGESTIONS ABOUT THE VARIOUS ORGANIZED COMMUNITY HEALTH SERVICES

LOCAL PUBLIC HEALTH SERVICES¹

Organization

1. Full-time, public health services on a regional basis should be provided in all parts of the Province. It is a provincial legislative responsibility to assure that they be established in areas now without full-time services. In very isolated areas resident public health nursing services and available health officer service should be directly provided by the Province. A regional health services organization which would draw together and co-ordinate all organized community health services and resources, including public health services, as outlined in Chapter IV, is suggested.²

Financing

2. The existing pattern of provincial support for local public health services should be reviewed and revised, so that municipal as well as health unit services are supported. It is suggested that a financial sharing arrangement of approximately 70 per cent payment by the Province and 30 per cent payment by the local area would be reasonable in predominantly rural or semi-urban regions and a financial sharing arrangement of approximately 60 per cent payment by the Province and 40 per cent by the region in urban regions.³

3. Incomes of medical officers of health, public health nurses, and other public health personnel should be revised regularly, so that they will be comparable to those in other medical, professional and skilled technical fields.

4. Basic salary levels and common pension arrangements for personnel should be set by the Province. The cost should be included as an ear-marked part of provincial grants to a regional health services board. Additional regional salary payments and increments could be paid. The staff would have greater freedom to change jobs, because income and pension rights would be assured, than under the existing administrative pattern.

¹ See Chapter I, pp. 11-31. for a detailed discussion of public health services.

² See Chapter IV, pp. 69-73.

³ See Chapter IV, pp. 72-73.

Staffing and General Functions

5. The medical health officer's functions should be, first of all, those of a medical administrator who is equipped to plan, to administer and co-ordinate, and to evaluate services. In the second place, he should be the local consultant and expert in epidemiology and community health research, not only for the communicable diseases but also for newer problems of the public's health, such as cancer, heart disease, and the chronic diseases in general. He should be involved in the provision of adequate community services for home care, the care of the aged, accident control, rehabilitation, mental health, and family planning, to mention some of the more important community-wide health problems now being faced.

6. Personal health care should, as far as possible, be carried out by physicians in clinical practice with the assistance of the health department staff, especially the public health nurses. Consideration should, however, be given to the fact that certain personal preventive services, such as immunization and multiphasic screening, may be more effectively provided on an organized community basis.

7. Undergraduate teaching in medicine should include preparation in sociology, psychology, statistics, and economics, which are the basic sciences necessary to an understanding of organized community health work and to public health and social medicine.

8. A combined preventive, teaching, and visiting bedside nursing service should be provided by the public health nurses.¹

9. Greater attention should be paid to the use of auxiliary nursing personnel and clerical staff so that skilled nursing time may be used to full advantage.

10. There should be further attention paid to the use of married nurses and nurses able to give part-time service.

11. There is need for further clarification of the functions, and, as a result, of the academic and training requirements for sanitary inspectors.

12. The establishment of courses under the auspices of educational institutions, in co-operation with the Ontario Health Department and the Canadian Public Health Associations, as has occurred at the Ryerson Polytechnical Institute, is commended as a desirable pattern for promoting better standards of selection and teaching and for providing the status, which sanitary inspectors feel is lacking at present.

13. A larger, regional administrative pattern than many municipal health department and health unit areas provide is necessary, if special and scarce personnel, such as dental public health officers, veterinary public health officers, health educators, medical social workers, and psychiatrists, are to be obtained and used to full advantage.²

Programmes

Communicable Disease Control in General

14. Routine reporting of communicable diseases by physicians should be restricted to the serious communicable diseases. Where information on the extent

¹ See also suggestion 33, pp. 78-79.

² See Chapter IV, pp. 69-73.

of other communicable diseases or on the level of immunity in a community is desired, regular inquiries and serological studies on a sampling basis could be used. Greater attention to reporting and to epidemiological studies of newer problems of the public health, such as cardiac disease, cancer, disabling conditions, and accidents, should be considered.

15. Although personal preventive care should in general be provided by personal family physicians, some personal preventive services, such as immunization, may be more effectively provided on an organized community basis in many cases.

Tuberculosis Control

16. Comprehensive screening and follow-up programmes of tuberculosis control are commended and should be developed in all communities.

Venereal Disease Control

17. There should be more intensive education of physicians on the importance of reporting cases of the venereal diseases and of obtaining contact information.

Sanitation

18. There is need for an on-going revision of existing environmental control legislation, so that standards and requirements may be kept in line with modern practice and so that provisions may be made for new environmental hazards. Common and precise province-wide interpretation and enforcement of requirements are needed.

Although the technical aspects of some basic environmental control programmes, such as water, sewage, garbage, milk, and meat control, are partly or entirely the responsibility of other than health authorities, the health supervision and control aspects should continue to be a public health responsibility.

19. There are still too many communities where the basic environmental services are inadequately met at present. These situations should be corrected as quickly as possible because their continuing existence is a hazard to the public health.

Maternal and Child Health

20. A copy of the birth notification should be sent routinely by local registrars to the health department in the community of current residence of the mother.

21. Public health nurses should be permitted to visit new mothers in hospital, so that unnecessary home visits will not be made.

22. Where group practices have been established, it is suggested that the health department second public health nurses on a scheduled basis to the groups to assist them in carrying out prenatal, post-natal, and well-baby care for their patients, including immunizations and home visiting as indicated.

23. Doctors in solo practice or in small partnerships should be invited to use the facilities of the health department building and centres and the services of the public health nurses on a scheduled basis for providing maternal and child health services for their patients.

24. Some economic arrangements for paying the doctors, either government or private, would be necessary so that all people would be able to seek maternal and child health services from a personal physician. Specific payments for regular prenatal, post-natal, well-baby, and pre-school child visits would encourage parents to seek and doctors to provide satisfactory supervision.

25. In rural and northern areas, where consultant obstetric and paediatric services are either difficult to obtain or unavailable, the proposed regional health services organization should retain consultants.^{1,2}

School Health Service

26. Routine pre-school and school physical examinations, as is now the trend in most areas, should be done by family physicians wherever possible. Some type of financial arrangement, either government or private, is needed, so that all parents could arrange for examinations and necessary care to be provided.

27. Health department school programmes, as is now the trend in most areas, should carry out mass screening procedures, with referral through parents to the family doctors for further examination and care, if indicated.

28. Routine booster dose programmes by health departments in the schools should be continued as a useful and economic method for assuring a high level of immunity among children against diseases for which specific immunizing agents are available. This arrangement would not preclude any family doctor from giving booster doses to children under his care, if he or the parents so wished.

29. There should be study of the possible greater use of auxiliary nursing personnel, such as registered nursing assistants, in performing simple and routine mass screening procedures.

30. It is not realistic to have a public health nurse or a registered nurse in each school on a full-time basis to provide first aid and minor care. An arrangement with local physicians and hospitals, where extensive care is needed and for athletic events is suggested. Teachers should be taught and permitted to give first aid and minor care during school hours.

31. School mental health services and general health counselling by the public health nurses in co-operation with other community mental health resources should be fully provided in every school.

32. School dental health programmes, including routine screening and education, with referral through parents to family dentists, should be developed in every school. Unless decided otherwise by local decision, treatment by the school dental service staff should be restricted to children from lower income homes.

Public Health Nursing

33. The health department should provide a generalized nursing service including visiting home nursing in all rural and smaller urban communities. In large communities, where the Victorian Order of Nurses and other voluntary associations have extensive programmes, duplication and overlapping of effort should be eliminated either by amalgamation with the health department

¹ See Chapter IV, pp. 69-73.

² See also suggestions under Community Hospital Services in this chapter, pp. 79-80.

service, if so agreed, or by purchase at cost of defined services from the associations by the health department. Visiting nursing association nurses, under the latter arrangement, could either be assigned some districts, as would also the public health nurses, in which they would provide a comprehensive programme, or could provide bedside care only over the entire community. Visiting nursing is a basic community service and should be supported on a definite basis from public funds and should not even partly be dependent on the uncertainties of voluntary fund raising. This arrangement would not preclude a sliding fee system as a part of financing, where felt to be desirable.

Newer Problems in Public Health

34. Public health departments should develop programmes to meet newer problems of community health in fields, such as chronic disease, care of the aged, home care, mental health, rehabilitation, mass screening and multiphasic screening, accident control, and family planning. Health education activities need to be expanded. Liaison functions among the various community services should be developed further.

Relations with Other Services

35. In rural and semi-rural regions the provision of space in the main hospital for the health department and for public health nursing services in other regional hospitals is a practical way of encouraging closer relations. Both parties should be involved in planning joint housing arrangements so that there is scope for future expansion of both.

In cities, joint housing would not, as a rule, be realistic. However, public health nursing offices and services should be provided in each hospital to facilitate liaison between the hospital and community services.

36. The medical officer of health should be a member of each hospital's honorary staff. He would be expected to attend meetings of the staff as a whole and be a member of any special committees on which his training and experience would be useful, for example, an infections committee.

COMMUNITY HOSPITAL SERVICES¹

Medical Staffing and Services

37. A regional pattern of the organized health services is suggested as a means of attracting more of the less common types of specialist, such as the radiologist, pathologist, orthopaedic surgeon, psychiatrist, ophthalmologist, otorhinolaryngologist, urologist, and dermatologist, to rural and semi-urban areas. They would serve all the hospitals and practising doctors and thereby could be assured of sufficient work and incomes. Depending upon local circumstances, payment could either be on a purely salaried basis or an agreed consultation fee basis with or without a basic salary. They would work from the regional base hospital where all special equipment, facilities, and ancillary staff would be located. In emergencies, and routinely in the case of the pathologist and radiologist, they would provide services in the other regional hospitals.

38. Group practice, as a means of attracting more basic types of specialist, such as the internist, general surgeon, obstetrician—gynaecologist, and paediatrician, should be encouraged through long-term loans for facilities by the provincial government and by the private prepayment plans.

¹ See Chapter II, pp. 33-50, for a detailed discussion of community hospital services.

39. In isolated and sparsely settled communities basic specialists should be retained on the same bases as outlined above, in suggestion 37, for less common types of specialist.

40. In northern and sparsely settled communities, where circumstances are such that private general practice is not feasible or is unlikely to develop, it is suggested that the regional health services organization retain general practitioners on a salaried basis, possibly with certain fee privileges when local conditions warrant these.

41. It is further suggested that, in rural and northern areas, in addition to adequate guaranteed incomes, satisfactory hospital facilities, ancillary staff and services, reasonable referral arrangements, and acceptable living accommodation should be assured.

42. The Ontario Department of Health fellowship programme, under which medical students receive financial assistance for their education and in return give a period of service in a rural area after qualifying, is commended but it remains to be seen whether it will have much impact on recruitment for rural areas, except for those with relatively large and wealthy populations.

43. Greater attention to primary and secondary education is necessary to assure that more pupils from rural areas and smaller urban communities may receive better preparation in the sciences and mathematics and, thus, become qualified to enter fields such as medicine. Greater efforts should be made to encourage more students from these areas to complete secondary school. Greater financial assistance from the Dominion and the Province is needed to enable qualified graduates to go on for further education and training.

Registered Nurses and Auxiliary Nursing Personnel

44. It is suggested that attention be directed to the more extensive use of auxiliary nursing personnel and clerical staff, so that skilled nursing time is used to full advantage.

45. Hospitals should provide necessary nursing in private as well as public sections, so that much private duty nursing could be eliminated. Private duty nurses often spend a good deal of time on non-nursing activities.

46. A saving in skilled nursing time could be achieved by further attention to the use of measures, such as progressive patient care.

47. Salaries for registered nurses, with increments for post-graduate education, need to be increased to a level comparable with other skilled work.

48. Greater attention should be given to the use of married nurses, even on a part-day basis, as is being done in some hospitals.

49. Courses to help nurses who graduated some years ago to refresh their skills, such as are provided by the Registered Nurses Association of Ontario, should be encouraged financially by the Province on a regional basis.

50. The encouragement to primary and secondary education, previously mentioned, is also important to future nursing recruitment.¹

51. The development of additional independent nursing schools, such as the Nightingale School in Toronto, should be encouraged. Ways for improving the academic content of nursing courses and for reducing the dependency of hospitals on service from student nurses should be studied further.

¹ See suggestion 43, above.

52. University courses should continue to provide education for those who are academically qualified and who are considering careers in specialized fields, such as teaching, research, administration, and public health.

53. Nursing schools in small- and medium-sized hospitals should be discontinued and be replaced by regional nursing schools. These could more readily obtain qualified teachers, clinical supervisors, and could provide courses meeting acceptable academic standards. Practical experience would still be gained in the regional hospitals. Special teachers could be shared on a block-time basis among several such schools. Special experience on a block-time basis could be arranged in the regional base hospital, the nearest mental hospital, and the nearest sanatorium.

54. Additional study of ways to attract more men into nursing should be carried out.

55. Courses for registered nursing assistants in small- and medium-sized hospitals should be discontinued and be replaced by regional courses. These could more readily obtain qualified staff. Because many students for such courses are married women who are reluctant or unable to leave their homes for long periods of time, as much practical experience as possible should be provided under supervision in local hospitals. Special academic and other teaching could be provided at a regional centre, possibly the base hospital, on the basis of a few days per month and for short intramural periods at the beginning and end of the course.

56. However, it is also necessary to direct further attention to the type of training needed. The course should be based on clarification of the functions auxiliary nursing personnel should perform. Salary levels will also need to be kept competitive with work requiring comparable training.

Some Other Professional Personnel

57. It is suggested that physiotherapists, qualified dietitians, occupational therapists, hospital pharmacists, and medical social workers be retained on a regional basis in rural and semi-urban areas. They could serve not only the hospitals but also other institutions and programmes and, thereby, would have sufficient work to make their employment economically warranted. The greater variety of work would also serve to attract personnel who may now be deterred.

58. Because enrolments in some existing courses in household economics, social work, and pharmacy are below capacity, the same suggestions for encouraging primary and secondary education as have been made for medical recruitment, are valid for these fields.¹

59. Under a regional hospital services pattern, more openings for supervised and salaried internships in hospital pharmacy could be developed.

60. The provision of additional courses in universities and technological institutes for physiotherapists and occupational therapists is suggested.

61. Medical undergraduate education and hospital medical staff education should include greater emphasis on an understanding of the functions of non-medical professional and technical colleagues, so that they will not be expected to assume responsibilities in prescribing therapy, which the doctor should take.

¹ *Ibid.*

62. Salary levels, except for hospital pharmacists, are in general competitive with other types of employment for such professional workers. Income levels should be revised regularly to assure that they continue to be adequate.

Hospital Administrators

63. A regional hospital services pattern would permit employment of a qualified, university-trained senior hospital administrator for a region. Experienced, extension-course graduates could serve as administrators in large hospitals, groups of hospitals, or, in some cases, as senior hospital administrators for entire regions. Especially if accounting, purchasing, laundry, and other services were centralized, local administrators with lesser training could serve the smaller hospitals in a region. The development of further courses for administrators of small hospitals, as at the University of Saskatchewan, is suggested.

Other Personnel

64. Under a regional organization, more efficient and better supervised laboratory X-ray, and medical records services could be developed in each region. Skilled and qualified medical record librarians, X-ray technicians, and medical laboratory technologists could be used to maximum advantage over all the hospitals in a region.

General Proposals on Personnel

65. The various professional and skilled technical groups should study intensively the further use of less skilled auxiliary personnel under qualified supervision. Unnecessarily restrictive professional and technical association policies should not be permitted to hamper a reasonable use of ancillary personnel under supervision.

66. The development of courses for ancillary personnel, such as food supervisors and occupational therapy assistants, and of short courses for personnel, such as surgical technical aids and orderlies, by the Ontario Hospital Association and individual hospitals is noted with commendation. As pilot projects they are most useful. But the proliferation of types of personnel and of courses under many different auspices can lead, if it has not already, to an uncontrolled and confused situation in admission standards, in course contents and in course purposes. The whole question of the training and use of technical and auxiliary hospital and health service personnel needs urgent clarification by all professional and technical groups concerned and by the provincial health, hospital, and education authorities, if acceptable common standards of training and teaching are to be established and if problems of supply are to be met.

67. Though we commend the efforts of professional, technical, and government bodies which have developed training programmes, it is our view that, in some cases, there has been undue emphasis on apprentice training at the expense of consistent academic standards. The development of courses, in association with academic institutions, such as the Ryerson Polytechnical Institute, is a trend to be encouraged. In general, it is our view that professional and technical associations should seek to have responsibility for longer, formal intramural and extension courses assumed by academic institutions. Associations should provide such courses only on an initial pilot basis. On the other hand, there seems to be a definite role for professional and technical associations in offering short courses in-service courses, and refresher courses for professional, technical, and auxiliary personnel.

Organization and Administration

68. Home care services and nursing home services which relieve pressures on hospital beds should be covered as benefits under the Ontario Hospital Insurance Plan or on some other basis.

69. Each large city and region should have a central bed registry for allotting beds in all hospitals and related institutional facilities to facilitate their most efficient use and the ready transfer of patients.

70. Each hospital should allot beds centrally so that the best use can be made of available space, rather than on a separate service or department basis.

71. A regional pattern of hospital organization would permit economies through group purchasing, accounting, laundry, and other readily centralized services. It would make it easier to obtain qualified professional and technical personnel, including administrative staff. It would facilitate the co-ordination of hospital services and the more efficient use of scarce personnel and facilities.

In rural and semi-urban regions, one hospital could be developed as a base hospital, with specialized staff and equipment. The other hospitals would provide emergency, general medical and obstetrical, and chronic care only. Separately operated and competing small hospitals in communities often only a few miles apart are no longer warranted for quality and economic reasons.

In large cities, in addition to large, specialized, central hospitals serving several regions or an entire province, other large general hospitals with specialized staff and facilities are needed to provide service to the people in the immediate area.

72. In order to facilitate the wisest planning and most rational use of all organized community health services, and resources, a regional health services organization which would draw together and co-ordinate all organized community health services, including hospital services, as outlined in Chapter IV, is suggested.¹

OTHER ORGANIZED COMMUNITY HEALTH SERVICES

Dental Services in Rural and Smaller Urban Communities^{2,3}

73. A salaried dental service, designed to attract new graduates to work for a time in rural and northern areas, should be established under the suggested regional health services organization.⁴ The dentist should have an office provided by the region in a hospital, or in the far North in a rail car. He should receive a fair salary. In areas where there are some but insufficient private dentists, his work could be restricted to those in lower income groups. He must have convenient consultant arrangements provided by experienced dentists, who should visit regularly to help with more difficult cases. They could be retained in a region on the same salaried basis, or a basic salary plus certain fee privileges, as was suggested for medical specialists.⁵ Suitable living accommodation for the dentist should also be assured, either adjoining the office or nearby. A further inducement to recruitment would be to offer graduate education fellowships to young dentists who have given two or more years of service in this programme.

¹ See pp. 69-73.

² See Chapter III, pp. 51-53, for a detailed discussion of the services about which suggestions are made in this section.

³ School dental services have been covered in suggestion 32, p. 78.

⁴ See Chapter IV, pp. 69-73.

⁵ See suggestion 37, p. 79.

74. Rural and small urban communities wishing to attract a private dentist should also assure him of suitable office and living facilities at reasonable cost.

75. More dentists are required. Additional federal and provincial support for teaching facilities and for fellowships is required.

76. As mentioned for doctors and other professional and technical health workers,¹ better teachers and educational facilities at the primary and secondary school levels are needed in rural and small urban communities. Unless more students with better academic qualifications take further education, future recruitment from such areas, not only for dentistry but for all skilled fields, is likely to be limited.

77. Since economic deterrents may be important barriers, a thorough study of higher educational opportunities for students from rural and smaller urban communities is proposed.

78. Intensive study should also be carried out on the more extensive use of auxiliary personnel in the dental field.

79. The base hospital in each region should provide facilities and beds for people, such as cerebral palsy cases, the mentally retarded, severe cardiacs, and haemophiliacs, who require medical supervision and/or general anaesthesia for dental procedures.

80. The entire pattern of paying for the care of people on general public assistance and of those receiving various categorical allowances should be altered to provide a full range of preventive and restorative dental care, including dentures, on other than a charitable and haphazard basis.

Rehabilitation²

81. In large urban communities, rehabilitation services, under whatever auspices, should be provided on a planned and co-ordinated area-wide basis, so that scarce staff and special equipment may be used to full advantage and so that duplication of services does not occur unnecessarily. The decision as to whether more generalized hospital and rehabilitation centre programmes or whether specialized centre programmes are preferable for any given disease should be made only after specific study.

82. Highly specialized facilities should be planned and co-ordinated on a province-wide basis or even, in some instances, on a nation-wide basis.

83. It is unrealistic to try to provide even basic rehabilitation services in small- and medium-sized hospitals on a separate basis. A regional rehabilitation service pattern provides the only realistic answer to the most economic use of staff and facilities. Only basic and straightforward problems should be handled in rural and semi-urban regions, either on an in-patient, out-patient, or home care basis. Complex cases should go to large general and specialized rehabilitation centres in large cities.

84. Because rehabilitation services are required not only in hospitals and other institutions but also in programmes of mental health, home care, and care of the aged, it is suggested that all basic rehabilitation services should be provided through a regional health services organization, which would draw together and co-ordinate all organized community health services.³

¹ See suggestion 43, p. 80.

² See Chapter III, pp. 53-56, for a detailed discussion of the services about which suggestions are made in this section.

³ See Chapter IV, pp. 69-73.

85. Suitable accommodation for severely handicapped children and young adults should be provided as part of any regional health services pattern.

86. Voluntary agencies presently providing specific physical rehabilitation services should work through the regional health services organization. Wherever available, physical rehabilitation services could be purchased from voluntary agencies by the regional organization on a defined cost basis. Agencies which do not provide general physical rehabilitation services should be encouraged to devote their attention to such important activities as public education, patient visiting, the provision of personal patient needs, and to the sponsorship of pilot projects.

Mental Health¹

87. It is difficult to determine the best pattern of services for attacking the many problems of mental health and to evaluate the worth of the varying approaches presently being tried. More extensive and intensive pilot studies, which can be carefully evaluated, are suggested before any final conclusions are reached. However, it is our general opinion that a regional pattern of organized health services, including mental health services, would allow the best use of scarce personnel and facilities in both urban and rural areas.

88. Psychiatric sections should be established, as staff availability permits, in larger urban hospitals and in the base hospitals of rural regions. Out-patient clinic facilities and day-care programmes should be an integral part of their services, just as they are for the Ontario Hospitals.

89. The mental health services should be integrated with the Ontario Hospitals system but also should be closely integrated with psychiatric sections in large urban hospitals and rural region base hospitals and with health departments, rehabilitation facilities, school programmes, and social counselling agencies. As outlined in Chapter IV,² a regional health services organization would be one means of drawing together and co-ordinating all organized community health services.

Care of the Aged³

90. A regional health services organization, as outlined in Chapter IV,⁴ could draw together all services for older people provided by the hospitals, the public health department, rehabilitation programmes, and home care plans.

91. In turn, these services should be co-ordinated with some type of regional welfare authority either on an integrated health and welfare administration basis or in close liaison.

92. There should also be close liaison with the voluntary senior citizens councils and with services and facilities for the aged, provided by religious and other voluntary auspices.

93. In the planning of services for the elderly in any region, attention should be given to the need for variety in the services and facilities so that the varying requirements for older people may be met.

¹ See Chapter III, pp. 56-58, for a detailed discussion of the services about which suggestions are made in this section.

² See Chapter IV, pp. 69-73.

³ See Chapter III, pp. 58-62, for a detailed discussion of the services about which suggestions are made in this section.

⁴ See Chapter IV, pp. 69-73.

Home Care¹

94. Organized home care programmes for all communities should be established on a regional basis by a regional health services organization in close liaison with a regional welfare services organization or by a joint regional health and welfare services organization. Such a system could assure integration of home care services with the hospitals, public health department, and other organized community health services.² The extent and variety of services to be provided should be determined on the basis of an assessment of the actual need in each region.

95. Purchase of services could be made on a cost basis from existing voluntary agencies in larger communities, provided that the agencies are prepared to meet acceptable standards of care. In rural areas and smaller urban communities, where there are either limited or no voluntary agencies providing home care services, the regional health services organization should provide these directly.

96. There would need to be some form of economic coverage which would encourage the use of home care services where suitable as an alternative to hospital care, since the latter is now covered as a benefit under the Ontario Hospital Insurance Plan.

Ambulance Service³

97. For rural areas and smaller urban communities, the proposed regional health services organization either should directly operate an ambulance service or should subsidize a private operator for providing a full-time service at reasonable cost to all and free to those unable to pay. This would permit the most economic use of equipment, the provision of trained staff, and make good, full-time service available to all residents, hospitals, and other institutions.

98. For isolated areas, a regionally based, provincially operated, air ambulance service is suggested.

99. In larger communities, the regional health services organization could operate some of its own ambulances to supplement private services for lower income groups. Financial arrangements should be made, where there is no public ambulance service, to assure that those unable to pay receive necessary service and that all the public have service available at reasonable cost.

Official Welfare Services, and Voluntary Health and Social Agency Services⁴

100. Where health services are regarded as basic for a large part or the whole community, for example, visiting nursing, homemaking, and ambulance services, they should be financed from public funds. The services could be provided either directly by the proposed regional health services organization⁵ or by the purchase of services at cost and at acceptable standards from existing voluntary agencies. Fees could still be charged to those able to meet all or part of the cost of services, if so decided as a policy.

¹ See Chapter III, pp. 62-64. for a detailed discussion of the services about which suggestions are made in this section.

² See Chapter IV, pp. 69-73.

³ See Chapter III, pp. 64-65. for a detailed discussion of the services about which suggestions are made in this section.

⁴ See Chapter III, pp. 65-68. for a detailed discussion of the services about which suggestions are made in this section.

⁵ See Chapter IV, pp. 69-73.

101. An intensive review and revision of existing public welfare administrative patterns and benefits should be undertaken. Deficiencies in public welfare benefits are found frequently to be at the root of many health needs of indigent and low income families. These include the cost of required drugs, the cost of preventive dental care for children, and for the elderly, the cost of dentures, glasses, hearing aids, and other appliances.

102. A combined regional health and social welfare services organization is a desirable long-term development. Its success will depend upon a change in both provincial and local welfare policy and practice in Ontario and also on the greater availability of qualified staff. Common province-wide policies and a regional pattern of welfare administration are necessary first steps. Further study through experimentation with a joint administrative pattern in selected urban and rural regions is suggested.

PART II

THE OTHER PROVINCES

FACTUAL SUMMARIES OF OTHER PROVINCES AND PROVINCIAL COMMENTS¹

NEWFOUNDLAND

General Data

Because of the absence of local government institutions in most sections of the island, official health activities have been developed almost entirely by the Province. The pattern of provincial health services has been shaped by the sparsely settled population and the isolation of many communities, which make private medical practice almost impossible in many areas except when assisted by government subsidy. Accordingly, the provincial Health Department has become extensively involved in the provision of public health services hospital, and medical care services. While some functions of the work of the provincial Health Department are centralized, most of the functions are performed by medical and nursing personnel who also look after the direct medical and nursing needs of the communities in which they are located.

Although the Province has assumed responsibility for several programmes initiated by voluntary groups, voluntary services remain as an important part of the health services picture in Newfoundland. In northern areas of the Province, the International Grenfell Association and the Notre-Dame Bay Memorial Hospital Association conduct preventive public health programmes and case-finding services assisted by subsidies from the provincial Department of Health. There are as yet no health units in Newfoundland and the relationship between the Department of Health and the part-time and full-time district Medical Health Officers is a dual one involving both medical care and public health duties.

Hospital and Medical Services

General

As of December 31, 1962, there were 1,100 beds and 140 bassinets in general hospitals operated by the Department of Health. There were 1,044 beds and 227

¹ The factual information in this chapter is derived directly, in cases *verbatim*, from the following sources: 1. Mennie, W.A., *Unpublished data prepared for the Royal Commission on Health Services*. (Ottawa: Dept. of National Health and Welfare, Research and Statistics Division, 1962.) 2. *Federal and Provincial Health Services in Canada*. (Toronto: Canadian Public Health Association, Second Edition, 1962.) 3. *Public Health and Welfare Services in Canada*. (A report prepared for the *Canada Year Book*, 1962.) (Ottawa: Dept. of National Health and Welfare, Research and Statistics Division, 1962.)

The outlines were modified to some extent by those to whom they were referred in the provinces. Comments received have also been included, but as noted in the Preface these will remain anonymous.

bassinets in general hospitals operated by non-government agencies, including religious orders, the International Grenfell Association, the community or municipal councils, and the Dominion military authorities. There were 548 beds in sanatoria for tuberculosis operated by the provincial Health Department and 38 beds in Grenfell hospitals. The Provincial Government provided 920 beds for the mentally ill. A children's rehabilitation centre of 31 beds and 57 beds on the medical floor of St. Patrick's Mercy Home were operated under non-government auspices. The St. John's General Hospital of approximately 471 beds is the largest in the Province and serves as a base hospital for the entire Province. It is an accredited institution and provides a wide range of services for both in-patients and out-patients, as well as the largest nurses' training school.

The Cottage Hospital Medical Care Plan

With the introduction of the Dominion-Provincial Hospital Insurance Programme in 1958, the hospitalization component of the original Plan became covered separately.¹ The Plan now offers home, out-patient, and in-hospital physicians' services to almost one-half of the Province's population. Started in 1935, it is a government-operated prepayment plan involving 19 hospitals, 65 hospital and district physicians, 10 nursing stations and a travelling sea clinic. The physicians working under the plan, though not fully established civil servants, are salaried officers who derive all but a small percentage of their incomes from the Department of Health. The plan is not self-supporting but is heavily subsidized through the Health Department. The general annual premium in most areas is \$10.00 per family or \$5.00 for single persons. In several economically wealthier areas the annual premiums are either \$16.00 or \$24.00 per family. Single persons pay one-half of the family rate. Additional charges may be made for private rooms, maternity care, dental extractions, out-patient drugs and appliances at modest rates specified by the Department. All transportation must be paid by the patient unless a certificate of inability to pay is received from the local representative of the Department of Public Welfare. Failure to pay the yearly fee does not disqualify a family from receiving care but an extra charge in the form of a late joining fee is levied when they seek hospital or medical care. People on public assistance are expected to pay part of the premium unless to do so would cause undue hardship. On referral by the local physician, the patient is eligible for medical care in general hospitals at larger centres.

Dominion-Provincial Hospital Insurance Programme and Children's Hospital and Medical Care Plan

The programme began in Newfoundland on July 1, 1958, and is operated by a division of the Health Department. The hospitalization components of two programmes, the Cottage Hospital Medical Care Plan and the Children's Hospital Plan, previously operated as a purely provincial responsibility, are now included in the plan. The Newfoundland Children's Hospital Plan started in January 1957, covered hospitalization and out-patient diagnostic services and from 1958 professional care in hospital for all children under 16 years. The professional care section of this plan continues in operation as a Children's Health Service.

In-patient standard ward services, out-patient laboratory and radiological services, encephalograms, cardiograms, basal metabolism estimates and interpretations, radiotherapy and physiotherapy for ambulatory patients, are included as benefits under the tax-supported Hospital Insurance Plan.

¹ See p. 92.

Transportation

The Department also has an extensive transportation system for staff and patients, including a fleet of cars, a floating clinic for the villages along the coast with no road connection and four smaller boats for use by medical officers. Voluntary agencies also operate a number of travelling clinics. By charter arrangements with a local air service, seaplanes and helicopters are available for special mercy flights.

Indigent Care

The Province provides a tax-supported programme for drugs, dressings, prosthetic services, dental care and welfare foods as well as hospital and medical care for indigents.

Public Health

Communicable Disease Control

The programme is under the direction of the Chief Medical Health Officer of the Department of Health and includes standard immunization procedures, the investigation of cases reported by medical doctors, isolation and quarantine as indicated. There is close relationship between the Chief Medical Health Officer and the isolation wing of the St. John's General Hospital.

In St. John's, immunization programmes are conducted in the schools through the departmental nursing service under the direction of a school medical officer. Immunization for pre-school children is conducted by the nurses of the voluntary Child Welfare Association subsidized by the Department of Health for this purpose. Largely through follow-up visits by nurses to newborn babies, it has been possible to obtain practically complete immunization of this group. The immunization programme includes assistance and co-operation in the organization of clinics for the inoculation of children of pre-school age. Travelling immunization teams consisting of a nurse and a recorder visit settlements outside St. John's, mainly in areas not provided with medical services, in order to carry out the immunization programme.

Venereal Disease Control

Treatment is free to all persons attending the central clinic at the St. John's General Hospital and to all Cottage Hospital subscribers and to medical indigents. The Province provides free penicillin to private physicians and reimburses part-time medical health officers and private physicians on a fee-for-service basis for the routine treatment of medical indigents and Cottage Hospital subscribers.

Tuberculosis Control

Tuberculosis has always been a major health problem. The services for the eastern half of the Province are centred in St. John's where the tuberculosis dispensary serves as the control and case-finding unit and the St. John's Sanatorium provides approximately 280 beds. In the western area, the Sanatorium at Corner Brook with 270 beds combines in-patient, out-patient, and control functions. In both regions the Newfoundland Tuberculosis Association renders valuable assistance in case finding and rehabilitation. The Grenfell Hospitals at St. Anthony, with a 30-bed sanatorium wing, and at Northwest River in Labrador, with eight beds, also provide treatment and control facilities. Sanatorium care for tuberculosis is free to all Newfoundland residents.

An extensive B.C.G. vaccination campaign includes school and pre-school children, student nurses, institutional staff, and contacts with known cases. A widespread case-finding effort by land and by sea is conducted in co-operation with the Newfoundland Tuberculosis Association. Because of the high incidence of tuberculosis and hence positive tuberculin reactors and also because of the extensive use of B.C.G. vaccine, mass screening through tuberculin testing has not been used. Repeated chest X-rays of susceptible groups and mass X-ray surveys are the basic case-finding techniques.

Sanitation

The Department of Health has a Chief Health Inspector and several regional health inspectors with appropriate staffs. The sanitation programme covers the standard range of activities with special emphasis on advice and inspection on sanitary installations in new buildings. This has become an important function in recent years because of the rapid population growth and resulting rapid extension of suburban areas where adequate water supply and sewage disposal systems do not exist.

The examination of food handlers has become a rapidly expanding service and routine health examinations have been established. An equally important branch of the work has been the holding of periodic courses for food handlers.

Public Health Nursing

The service includes nurses employed by the Department of Health other than in the St. John's General Hospital, the two tuberculous Sanatoria, and the hospital for mental and nervous diseases. The staff consists of about 115 nurses, divided approximately one-third in St. John's, one-third in nursing stations in districts outside St. John's, and one-third on the staffs of the Cottage Hospitals.

The St. John's District Nursing Programme provides a combined preventive—public health and home nursing service in co-operation with the Child Welfare Association, and the Victorian Order of Nurses. It covers communicable disease control, tuberculous control including B.C.G. vaccination, visits to the indigent sick, maternity service with prenatal visits, prenatal clinics, and post-natal visits, and pre-school and school health programmes. The programme of the public health nurses outside St. John's includes communicable disease control, tuberculous control, sickness visits, general and prenatal clinics, pre-school and school health programmes, and maternity service. The objective of the nursing stations and districts is to bring preventive and curative nursing and a degree of medical service to isolated and thinly populated areas where there is no doctor.

Laboratory Services

A complete laboratory service is provided through the public health laboratories at St. John's and Corner Brook. Complete autopsy and pathological services are offered to all hospitals in the Province.

Health Education

The Health Education Division develops health education programmes, works with the government and voluntary agencies, assists in service training, conducts campaigns, and prepares materials.

Nutrition

Nutrition education and the provision of supplementary foods to certain vulnerable groups are the two main aspects which try to improve the nutritional

status of the population through a distribution of dietary supplements and the artificial fortification of food products. Talks, lectures and instructions are also provided. Staff nutritionists offer a consultant service in dietetics to the smaller hospitals and to schools.

The Department of Health distributes free cod liver oil and concentrated orange juice to infants and expectant mothers at prenatal clinics, through Cottage Hospitals, medical health officers, nurses in districts and some Red Cross branches. Cod liver oil is also available free for pre-school children. Enriched flour has been mandatory for many years.

Maternal and Child Health

The Department does not maintain a separate division. Preventive services throughout the Province in the field of maternal and child health are integrated with and decentralized through the activities of the medical health officers and the public health nurses. Activities include school health services, the immunization programme for pre-school and school children, and various maternity services, such as prenatal clinics and prenatal and post-natal home visits. The Child Welfare Association in St. John's assists with the maternal and child health programme.

School Health Service

The School Health Service was inaugurated in January 1959. The School Medical Health Officer is responsible for the administration of school health services under the Chief Medical Health Officer of the Department. Regular institutes and conferences are held with school principals and teachers. Contact with all schools in St. John's is maintained through the school nurses.

There is also a school nursing programme in Corner Brook employing two part-time practitioners and the Victorian Order of Nurses. Elsewhere in the Province there are between 12 and 15 part-time or full-time married nurses doing school work in various communities. Local medical officers provide some services but do not carry out routine inspections.

School Dental Service

The Director of Dental Health divides his time between a children's clinic in St. John's and educational supervisory work throughout the Province. A full-time assistant dental officer is employed at the clinic. The Province subsidizes services by private dentists elsewhere to provide restorative and prophylactic work for school children, particularly during the first two years of school attendance. In addition any school age child of indigent parents may receive dental care on the certificate of a welfare officer.

Rehabilitation

There is a division of rehabilitation under a Provincial Co-ordinator. A free vocational rehabilitation service to disabled persons is provided in co-operation with public health, welfare, education and employment authorities, and with voluntary groups. It also works closely with the Workmen's Compensation Board. The division co-ordinates the case services required in rehabilitation, such as case finding, assessment, medical treatment, vocational training, job placement, and community education and organization. It maintains a case registry. The principal voluntary agencies are the Newfoundland Tuberculosis Association, the Newfoundland Society for the Care of Crippled Children and Adults, and the Canadian National Institute for the Blind, Newfoundland

Division. In 1960, the Newfoundland Rehabilitation Council was formed, representing government departments, voluntary health and welfare groups, service clubs and others, to co-ordinate and extend rehabilitation activities. A rehabilitation centre is being planned. The Division employs two rehabilitation officers to carry out field services throughout the Province. The Tuberculosis Association with a staff of four rehabilitation councillors and the National Employment Service work closely with the Division.

Medical restorative services on an in-patient and out-patient basis are covered under the Hospital Insurance Plan.¹ Residents of Cottage Hospital areas and children under the age of 16 are covered under medical care plans.² The St. John's General Hospital, operated by the Province, has a physical medicine department and various out-patient clinics. A children's rehabilitation centre operated by the Newfoundland Society for the Care of Crippled Children and Adults serves children up to age 16. Follow-up field services to crippled children outside St. John's are provided by a social worker and physiotherapist and mobile clinics have been instituted under the care of the centre's physical medicine specialist. Speech therapy is also provided. A prosthetic appliance shop at the St. John's General Hospital manufactures appliances and limbs. The Health Department supplies prostheses free of charge to patients unable to pay. The Health Department employs a director of physical medicine who serves as a consultant. The physiatrist is also chief of the Physical Medicine Department of the St. John's General Hospital and Medical Director of the Children's Rehabilitation Centre.

In co-operation with the Department of Public Welfare, needy disabled persons are furnished with social allowances and transportation while undergoing treatment through the federal-provincial Technical and Vocational Training Assistance Act. The Department of Public Welfare pays for transportation and maintenance of deaf children at special schools and of blind children in Halifax. Four special classes for retarded children are operated by local branches of the Newfoundland Association for the Help of Retarded Children.

The Province has supported the establishment of a research and treatment centre for alcoholism.

Chronic Disease Services

Treatment and rehabilitation services are provided at the St. John's General Hospital. The Canadian National Institute for the Blind operates training and employment services, including canteens and a sheltered workshop. Other voluntary groups concerned include the Canadian Red Cross, the Victorian Order of Nurses, the St. John's and District Branch of the Canadian Diabetic Association, and service clubs.

Mental Health

This is centred around the Hospital for Mental and Nervous Diseases outside St. John's, with approximately 950 beds. It provides out-patient clinics and a day care programme. The St. John's General Hospital also has an out-patient service. All services are provided free to Newfoundland residents.

¹ *Ibid.*

² See p. 92.

Home Care

Under the Cottage Hospital Medical Care Plan, certain domiciliary medical and nursing services are provided. The district nurses provided some home service in more remote areas. In St. John's a combined public health nursing and domiciliary visiting programme is carried out by the nurses. In Corner Brook the Victorian Order of Nurses are paid by the Province for home nursing to indigents, diabetics and tuberculosis cases. The Welfare Department may pay voluntary agency nurses to visit people also.

Welfare Programmes

The Department of Public Welfare administers directly all welfare programmes in Newfoundland including the Mothers' Allowances, the categorical allowances shared with the Dominion, and general public assistance. It also directly administers Child Welfare, unmarried mothers' programmes, and adoption programmes. The cost of care in voluntary or public institutions is borne by the Province.

A home for the aged and infirm is operated in St. John's. The Government pays in whole or in part for care in other homes for the aged and in boarding homes. It also provides capital grants to homes and housing projects.

Voluntary Agencies

As indicated previously, the programmes of all agencies, particularly the Newfoundland Tuberculosis Association, the Canadian Cancer Society, and the Canadian Red Cross have been closely integrated in many fields of public health. The International Grenfell Association receives support from the department and carries on a hospital medical and health service in northern Newfoundland and Labrador. Started with financial aid from the Grenfell Organization, the Notre-Dame Bay Memorial Association operates a hospital and medical service in one area of the northeast coast.

Provincial Comments

The importance of close association between public health and other health care services was stressed. It was pointed out that the medical officer of health must be adequately paid and that his position in any re-orientation of services should be clearly defined. Emphasis was also given to the continuing great importance of a tuberculosis control programme in Newfoundland.

PRINCE EDWARD ISLAND

Public Health

Organization

All public health services in the Province are provided by the provincial Department. Charlottetown and Summerside, the two largest centres of population, each employ a part-time health officer. Reports on services provided by the Department's staff, such as inspection of pasteurization plants, water supply, and restaurants, are submitted to these health officers, frequently with the Department's recommendation on appropriate action. The City of Charlottetown refunds one-half of the salary of a department public health nurse serving the

city schools and provides space for a dental clinic. Otherwise, there is no municipal support to any public health service. The Department operates essentially as a single health unit at the provincial level.

Sanitation

This Division is under the direction of a qualified public health engineer responsible to the Assistant Deputy Minister. There are six sanitary inspectors. This staff provides a wide variety of services, including inspection of tourist accommodations, eating establishments, pasteurization plants, public and private water supplies, sewage disposal systems, bathing beaches, trailer parks, and camping areas. The public health veterinarian attached to this Division is responsible for inspection of all slaughter houses and for supervision of the production and handling of raw milk going to the pasteurization plants.

Communicable Disease Control

The Assistant Deputy Minister is responsible for the investigation of cases of communicable disease and in the operation of the provincial immunization programme. Specimens from cases of epidemic or communicable disease are sent to the laboratory in Halifax, Nova Scotia.

A province-wide programme of immunization is carried out every four years with emphasis on pre-school and school children. Immunization clinics are held at Charlottetown, Summerside, and in other centres on a regular schedule throughout the year.

Tuberculosis Control

The Division is responsible for the operation of the Provincial Sanatorium, the Mobile Survey Unit and the diagnostic clinics. The work is centred in the Sanatorium which has about 90 beds for the treatment of tuberculous patients. The Prince Edward Island Tuberculosis League prepares public information and assists in local organization before setting up community surveys. The out-patient section conducts clinics for the examination of contacts of known cases and for follow-up of discharged cases.

An intensive programme of tuberculin testing by the Heaf method, followed by X-raying of positive reactors has been carried out. B.C.G. vaccination is reserved for limited groups which have an occupational or environmental hazard of exposure, including student nurses and case contacts with negative tuberculin tests.

Chest clinics are held at the Provincial Sanatorium and periodically at the Health Centre, Summerside, and in general hospitals at three other centres. They also examine discharged patients, contacts, and patients referred by physicians. Since 1959 treatment and care have been provided without direct charge.

Venereal Disease Control

Emphasis is placed on the provision of adequate diagnostic and treatment facilities, case finding, and public education. The Division maintains a central clinic in Charlottetown where free medical and laboratory services are available for the diagnosis and treatment of all reported cases and contacts. Penicillin is supplied free to physicians and fees are paid to physicians for the diagnosis and treatment of indigent cases. Mass testing through a compulsory pre-marital examination, and on all hospital admissions and other selected groups, is part of the programme.

Maternal and Child Health

There is no separate division but a child and maternal health service is conducted by the public health nurses of the Division of Public Health Nursing under the direction of qualified medical practitioners. An active programme is carried out throughout the Province, including prenatal classes in Charlottetown and Summerside, prenatal home visits, visits and instruction of new mothers in hospital, follow-up or post-natal home visits, home visits concerning pre-school children, and child health conferences on a weekly or monthly basis. All hospitals are visited weekly by the nurses. Classes in obstetrical nursing are conducted for hospital and public health nurses.

School Health Service

A comprehensive immunization programme for the protection of school children against diphtheria, tetanus, smallpox and poliomyelitis is carried out as a continuation of infant and pre-school inoculation. Public health nursing services are provided to all primary and secondary schools in the Province, with emphasis on children referred by teachers for special problems. The Province's nutritionist co-operates with the public health nurses in promoting good food habits. Steps are taken to further safeguard the physical health of pupils through supervision of water supplies and sewage disposal by the Division of Sanitary Engineering. Problems of mental health in school children are referred to liaison teachers who have had special training and who serve on the staff of the Mental Health Clinics.

School Dental Service

The Division carries out dental education programmes and a programme of free treatment for children in Grades I and II in many rural areas. Clinics for the topical application of fluoride are conducted by dental hygienists in as many districts as the staff can cover. The Director has been instrumental in setting up a preventive orthodontic clinic at Charlottetown. Dental welfare services for children in needy circumstances in urban areas come under the supervision of the Division.

Cancer Control

The Province provides the services of a medical specialist in cancer control who acts as consultant to members of the medical profession, provides X-ray and radium therapy to cancer patients, and maintains statistics on all cases of cancer reported to his Division.

Diabetes and Rheumatic Fever Services

Drugs and testing materials for the control of diabetes are provided by the Province at no cost to the patient. Similarly, drugs for the prevention of recurring attacks of rheumatic fever are supplied on prescription of the attending physician.

Laboratory Services

The Division of Laboratories provides public health laboratory services to all other Divisions of the Department, medico-legal services to the Attorney-General's Department, and animal laboratory services to the Department of Agriculture, as well as clinical services to all private physicians and a wide range of more specialized tests to the general hospitals. Supervision of the equipment and quality of laboratory work in all hospitals is also a function of the Division.

Hospitals and the Hospital Insurance Programme

According to the Canadian Hospital Directory, 1962, Prince Edward Island had eight public general hospitals operated by lay or religious organizations providing 667 beds set up. Of these, 23 beds were used for chronic illnesses and 644 for general use. In addition, the three public special hospitals operated by the Province provided 474 beds of which 30 were for chronic illness, 354 for mental illness, and 90 for tuberculosis.

There is a Hospital Commission of which the Deputy Minister of Health is the Executive Director. The tax-supported Hospital Insurance Plan provides in-patient services and a full range of out-patient services, including the use of radioactive isotopes with interpretations, specified laboratory and radiological diagnostic procedures with interpretation, the use of radiotherapy facilities where available, the use of approved physiotherapy facilities, provision of drugs, biologicals, and pharmaceutical supplies for emergency diagnosis and treatment, as well as the services of employees of the hospital.

Mental Health

The Province is served by two hospitals for the care of the mentally ill. One is designed essentially to provide for active treatment cases and diagnostic services. Care is provided free of charge. A Mental Health Clinic operates in Charlottetown to provide consultant and diagnostic services to family physicians and to health and welfare agencies without charge to the patient. Psychotherapeutic procedures are also offered. The clinic serves the population of the western section of the Province from a sub-centre on two days a week.

Active liaison with the Department of Education is maintained through a guidance consultant officer. A service of remedial classes is offered for children with speech or reading problems.

Rehabilitation

Residents insured under the Hospital Insurance Programme are covered for patient care and specified out-patient services including physiotherapy. Chronic and convalescent care is also available. In severe cases, patients may be sent to centres outside the Province for assessment, treatment and rehabilitation. The only facility is the 30-bed Rehabilitation Centre located in a wing of the Sanatorium. It provides medical assessment and treatment, including surgery, physiotherapy and occupational therapy and operates a brace and boot shop and a special education class. The Co-ordinator of Rehabilitation for the Province is the Deputy Minister of Welfare and Labour. Assessments of applicants and patients are conducted by a four-member medical team constituting the Medical Advisory Board. The Co-ordinator is responsible for vocational assessment, counselling disabled persons, and arranges for medical services, vocational training, and placement in co-operation with other agencies. One rehabilitation counsellor is employed. Sources of referrals include the Workmen's Compensation Board and voluntary agencies, as well as doctors and self-referrals. In needy cases, arrangements are made with the Rehabilitation Council which receives a portion of the Easter Seal and March of Dimes proceeds to pay for medical assessment or treatment. A provincial vocational school is in operation and special job placement is arranged through the National Employment Service officers at Charlottetown and Summerside. In addition to the centre, the Department has a field staff of public health nurses who detect disabling

conditions among children through regular home visits and school health examinations. They counsel parents and assist in referring children for assessment and treatment.

The Charlottetown Rotary Club co-ordinates the Easter Seal Campaign and supports the Rehabilitation Council which provides financial assistance towards the cost of transportation and medical services for needy children who require treatment outside the Province. The Junior Red Cross also assists through its Crippled Children's Fund. In 1960, a speech therapist was employed by the Mental Health Division to treat speech defects. Special educational facilities are sponsored by the Education Department. There are four branches of the Prince Edward Island Association for Retarded Children. The Cerebral Palsy Association also operates a special class. The Health Department has recently opened a small hospital training school for retarded children in Charlottetown.

There are few specialized health programmes organized for persons with specific diseases apart from those for mental health and tuberculosis. The Canadian National Institute for the Blind, Maritime Division, has opened a centre for the blind at Charlottetown and provides home teaching, employment, recreation, and pre-school services to registered blind people. The Maritime Division of the Canadian Paraplegic Association employs a rehabilitation officer who extends his services to Prince Edward Island patients. The Charlottetown branch of the Canadian Diabetic Association, concerned with case finding and educational work, has requested the provincial government to distribute free insulin to those unable to afford it. The branches of the Retarded Children's Association and the Cerebral Palsy Association are developing broader programmes of special education. The Prince Edward Island Chapter of the Multiple Sclerosis Society provides some patient services but devotes most of its efforts to research. The Prince Edward Island Chapter of the Canadian Foundation for Poliomyelitis and Rehabilitation gives financial support to the Rehabilitation Council and has assisted in establishing an Occupational Therapy Department of the Rehabilitation Centre.

Almost all general hospitals in the Province now have rehabilitation services either on a part-time or full-time basis.

Home Care

There are no organized home care plans in the Province.

Care of the Aged

This is a function of the Department of Welfare which provides institutional care, including professional medical services, to some 250 persons in two homes. In addition, a very considerable number of such people are boarded out in various private homes throughout the Province under the auspices of the Welfare Department.

Welfare Programmes

Aside from the federal-provincial categorical allowances, the Department of Welfare and Labour provides Mothers' Allowances. The Department provides direct social assistance in rural areas and assumes 75 per cent of the cost of assistance granted by the City of Charlottetown and the incorporated towns and villages who are responsible for general assistance to indigents. The Department also operates a province-wide programme of financial aid to families where the breadwinner is suffering from tuberculosis and unable to support his family.

Under the Unemployment Assistance Act, the Dominion Government shares in the cost of aid to needy unemployed persons up to 50 per cent of costs. The Province has regulatory powers over municipal administration of general assistance.

In Prince Edward Island, child care and protection services, including unmarried parents' and adoption services, are administered by the Province. The cost of maintenance and care of children by a voluntary or public agency is borne entirely by the Province.

Provincial Comments

The Province's size has resulted in a unitary pattern of service. Close ties between public health services and other health care services are felt to be essential.

NOVA SCOTIA

Public Health

Organization

The Province, with a population of 737,000, is divided into eight provincial health units, and a municipal unit in the City of Halifax, which conduct the local public health services. However, throughout the Province the municipal authorities are left with certain responsibilities under the Public Health Act. It provides that every municipality must have a Board of Health and that the municipal Health Officer shall be the Health Unit Director in the area concerned, except for cities which have a full-time Medical Health Officer. The City of Halifax has a full-time municipal Health Department.

The new Public Health Act of 1962 abolished district boards of health and replaced them by municipal boards of health. The Health Unit Director is the Medical Health Officer and Executive Officer of each municipal board. Municipal boards of health can appoint an additional part- or full-time medical health officer if they so desire. The intent is that a majority, but not all, municipal board members shall be members of the municipal council which appoints them. Several councils have appointed council members only to their respective boards of health.

The provincial health units serve a population which varies between 50,000 and 75,000 each. The entire cost of operating and staffing the provincial health units are responsibilities of the Province alone. In this field there is no municipal sharing. Each health unit is directed by a full-time qualified Medical Health Officer who directs the public health nurses, sanitary inspectors, a nutritionist, a dental hygienist, and a rehabilitation officer in carrying out their respective programmes. An experimental programme is in operation using certified nursing assistants.

Over-all direction comes from the specialized divisions of the Department. The Central Office provides consultation in maternal and child health, communicable disease control, public health engineering, radiation hazards control, mental health, dental health, nutrition, rehabilitation, health education, and other health fields.

Sanitation

The local programme under the health units employs 23 sanitary inspectors on health unit staffs. The services include supervision of milk supplies, public and private water supplies, school sanitation, garbage and refuse collection and disposal, food handling, restaurants, housing, and rural-urban sanitation. When necessary, towns are encouraged to seek advice from the provincial Environmental Hygiene Division through the health unit director.

Communicable Disease Control

Communicable disease control consists of local reporting of these diseases requiring notification by regulation, implementing isolation and quarantine measures, investigation of outbreaks, and a programme of immunization particularly of pre-school and school children. The activities are carried out by the health unit directors, public health nurses, and sanitary inspectors.

Tuberculosis Control

There are two provincial sanatoria, the Nova Scotia Sanatorium at Kentville and the Point Edward Hospital at Sydney. These are operated by the Province. It also co-ordinates the preventive service provided jointly by the Department of Health and the Nova Scotia Tuberculosis Association. Case-finding and preventive services are operated on a regional basis. This is a major activity of the field staff, particularly of directors of the health units and the public health nurses. Each unit is responsible for case finding and diagnosis, together with investigation and follow-up of contacts. Heaf tuberculin surveys have recently replaced mobile mass X-ray services. Those with positive tests are X-rayed at local hospitals under the out-patient diagnostic services plan of the Nova Scotia Hospital Services Commission or by the portable X-ray equipment of the health units. The Nova Scotia Tuberculosis Association also supports a case-finding programme by providing nursing personnel to carry out the tuberculin testing in certain areas. All patients entering hospitals are given an admission chest X-ray. B.C.G. vaccine is reserved for persons with occupational hazard, or contacts. As a result of progress in detection and treatment, sanatorium beds were reduced from a high of 1,246 in 1955 to 555 in 1961.

Sanatoria patients are given vocational assistance under the rehabilitation officers of the Tuberculosis Control Division. The Co-ordinator of Rehabilitation for the Province is responsible for patients outside sanatoria and works closely with the Tuberculosis Association.

Venereal Disease Control

Venereal disease work with emphasis on case finding is carried out by the health units. Outside the Halifax area, physicians are reimbursed for the examination and treatment of reported cases and suspects on a fee-for-service basis. A special clinic in Halifax at the Victoria General Hospital gives free diagnostic and treatment services.

Maternal and Child Health

The Division of Maternal and Child Health defines the problems, assesses curative and preventive services, and provides educational and consultative services to the district health units and local authorities. The aim is to supplement the work of the family doctors.

The public health nurses provide prenatal classes and teaching by home visiting. The Victorian Order of Nurses in certain cities facilitates the early visiting of infants. Follow-up is through post-natal home visits. The programme is supported by consultation services of an obstetrician and paediatrician whose services are available in any part of the Province. The objective is to ensure that all children receive the best possible medical care and supervision, particularly the newborn. Pre-school services are provided to supplement the work of the family physician through child health conferences and immunization clinics and are often held jointly with the Victorian Order of Nurses.

School Health Service

Public health nurses visit the schools throughout the Province and an effort is made to discover any defects in the children. The provincial Division of Child and Maternal Health and of Communicable Diseases is interested in the study of all problems related to physical and mental health of all age groups. Hearing Test Units visit schools throughout the Province periodically to conduct audiometric tests.

All children entering school are given a complete inspection by the public health nurse. Vision testing in certain school grades is provided. The immunization status of the child is also reviewed at certain grade levels. Tuberculin test programmes are carried out in elementary and secondary schools. In the high schools, the public health nurses conduct student interviews on health problems.

Public health nutritionists carry out an education programme in the schools on special problems and on over-all nutrition. The nutritionist also offers a consultation service on school lunch programmes to institutions and to other interested groups.

School Dental Service

The Dental Health Division carries out educational, preventive, and case-finding activities. Dental hygienists give instruction in caring for the teeth and give applications of stannous fluoride to children in areas which do not have a public water supply. A dental treatment service is given whenever mobile units can be staffed. Over 20 per cent of the population are using fluoridated water.

Three mobile dental units are organized to conduct an educational programme and provide free treatment for children in remote rural districts. They also serve the provincial sanatoria during the winter months and school vacations.

Laboratory Services

The Department of Public Health operates a Provincial Laboratory in Halifax for work in bacteriology, virology, pathology, and biochemistry, etc.

Hospitals and the Hospital Insurance Programme

The Canadian Hospital Directory, 1962, lists 60 public hospitals both general and special with a total number of beds set up as 7,285. The distribution is as follows:

Institutions	Beds	Chronic	Convalescent	General	Mental	Orthopaedic	Tuberculosis
60	7,285	20	53	3,633	3,085	8	485

These hospitals are operated under lay, religious, municipal, and provincial auspices. In addition there are two privately operated hospitals with a total bed capacity of 16, operated by a lay group, for general use.

The Dominion Government Departments of Veterans Affairs, Immigration, National Health and Welfare, and National Defence operate five hospitals with a total bed capacity of 636 beds of which 163 are for chronically ill, 451 for general use and 22 for the mentally ill.

The Hospital Insurance Programme in Nova Scotia is administered by a separate Hospital Insurance Commission reporting direct to the Minister of Public Health. In addition to required in-patient services and emergency out-patient care within forty-eight hours of an injury, an extensive range of out-patient services is provided. These include minor medical and surgical procedures, blood, radio-therapy for malignancy, physiotherapy where available, services other than medical of the Nova Scotia Tumor Clinic, specified laboratory examinations and all diagnostic radiological examinations, electroencephalograms, and necessary interpretation. Financing is by a special sales tax. Indigents are, therefore, covered as is anyone else.

The Commission tries to encourage the hospital to make use of the local provincial medical health officers. Much of this depends on the man and on the attitude of the hospital board. However, in general there is good relationship. At the provincial level, there is close integration. For example, the Deputy Minister of Public Health is a consultant on public health to the Commission. The Administrator of Health Units is a member of the Commission Committees on Operating Room Safety and Hospital Construction. The Nursing Consultant on Child-Maternal Health in the Department of Public Health is a member of the Committee on Nursing Services and sits in on the Committee on Hospital Construction. The Director of the Division of Consultative Services of the Department of Public Health is a member of the Commission Committee on Statistics and Research. The Director of the Division of Child-Maternal Health and Communicable Disease Control is Vice-Chairman of the Committee on Hospital Infections and a member of the Hospital Construction Committee and the Personnel Education Committee. The provincial Bacteriologist is a member of the Hospital Infection Committee.

In each hospital there is a Hospital Standards Committee basically made up of the Chairman of the Board, the Administrator, and a member of the medical staff appointed by the hospital. There is also a Medical Staff Sub-Committee of the Standards Committee.

There is a regional hospital pattern divided into nine regions, with a regional hospital and satellite local hospitals in each region. Cases requiring more complex diagnostic and treatment services are referred to the regional hospital which has approximately 200 beds, a well-equipped laboratory and a pathologist. The regional laboratory provides histology, biochemistry, bacteriology, and haematology.

The regional hospital has a well-equipped X-ray department. A regional hospital usually has some psychiatric beds and out-patient psychiatric services are being developed in connection with the out-patient departments. The regional hospital also has some 20 reactivation medical rehabilitation beds with a physiotherapist and an occupational therapist. There is also an intensive care unit within the hospital and quite an extensive out-patient and emergency department.

If a patient requires more complex diagnostic and treatment services, then he is transferred to a referral hospital. The referral hospitals are the Victoria General Hospital, the Children's Hospital, the Halifax Infirmary, and the Grace

Maternity Hospital in Halifax. These hospitals are equipped and staffed to provide specialized services. For example, the Victoria General Hospital has a tumor clinic with a Cobalt bomb unit. It also provides neurosurgery and cardiovascular surgery.

Mental Health

There are three divisions in the programme.

The Nova Scotia Hospital is principally an active treatment centre. There are about 530 resident patients. The admission rate is about 1,500 per year. Care is free for patients requiring active treatment.

The Community Mental Health Programme has plans for 10 mental health clinics throughout the Province. In 1961, seven were in operation with one or more psychiatrists and other personnel. A local board of management is in charge although about 90 per cent of the funds come from the provincial Public Health Department.

Chronic mental patients are received in eight Municipal Mental Hospitals. The Province pays 50 per cent of the net cost of treatment providing the hospital meets approved standards. In 1961, four hospitals were approved and 70 per cent of patients were in these four hospitals. The smallest municipal hospital has about 60 patients and the largest 500.

Rehabilitation

Medical rehabilitation under the Hospital Insurance Plan is available in the Nova Scotia Rehabilitation Centre, the Physical Medicine Department of the Victoria General Hospital, and in general hospitals with physiotherapy departments. The provincial Vocational Rehabilitation Programme organized in the Department of Public Health, under the provincial Co-ordinator, is co-ordinated with various organizations which provide restorative, vocational or social services for the disabled. The Rehabilitation Division does not pay for individual treatment services but, in selective cases, may provide maintenance for patients with a favourable prognosis receiving out-patient treatment. The Department of Education works closely with the Division as well as with the National Employment Service.

Services in Nova Scotia are provided by over 30 public and voluntary agencies. Through their combined efforts the Nova Scotia Rehabilitation Council was formed. This Council serves as an advisory body and as a co-ordinating entity. It also operates the Nova Scotia Rehabilitation Centre of 20 beds for in-patients as well as an extensive out-patient service, and an Appliance and Brace Centre.

Among the voluntary agencies, the Nova Scotia Society for Crippled Children and the Canadian Foundation for Poliomyelitis are very active in the field of rehabilitation. The Nova Scotia Hospital Insurance Plan covers medical restoration on an in-patient and out-patient basis at the Department of Physical Medicine in the Victoria General Hospital, Halifax. Social services are also offered. The Nova Scotia Rehabilitation Centre in Halifax provides a comprehensive rehabilitation service to disabled children and adults. Its major service is to out-patients. It has a 20-bed in-patient unit and a staff of physicians, physiotherapists, occupational therapists, psychologists, social workers and vocational councillors.

The Children's Hospital in Halifax provides specialized care to children with orthopaedic defects and other chronic conditions. Out-patient clinics for various

diagnostic groups are conducted through these facilities as well as by the Halifax Infirmary. The Nova Scotia Society for Crippled Children operates a mobile diagnostic clinic and consultative service to outlying areas. The Nova Scotia Brace and Appliances Centre, Halifax, operated as a Division of the Nova Scotia Rehabilitation Council provides a brace, splint and orthopaedic boot service. For indigents, the cost of appliances are met by sponsoring agencies or the Department of Public Health under the Medical Rehabilitation and Crippled Children's Grant. The Public Health Department has also arranged with the federal Department of Veterans Affairs to refer patients to the prosthetic centre at the Camp Hill Hospital which supplies services at cost.

The Rehabilitation Co-ordinator has developed a case-finding and referral system whereby disabled persons may receive assessment counselling, restorative vocational training and job placement services. Three rehabilitation counsellors in the tuberculosis programme also carry out field services under his jurisdiction. A medical assessment team of an internist and physiatrist screen all applicants and obtain reports from medical specialist consultants in selected cases. Close relations are maintained with the National Employment Service and the Department of Education.

The Nova Scotia Society for Crippled Children co-ordinates the work of local service clubs and other agencies in providing assessment, treatment, orthopaedic appliances, and personal aids and ancillary services for physically and mentally handicapped children and maintains the Crippled Children's Central Register. It has a field worker, a public health nurse who organizes diagnostic clinics in smaller towns and arranges for further assessment and treatment in Halifax hospitals and clinics. Twenty-six clinics were planned for 1961.

Speech therapy clinics are also conducted throughout the Province by two speech therapists. Other services provided by the Society include counselling, transportation and a camp.

Special auxiliary classes for the mentally retarded as well as physically handicapped children are operated by a number of school boards. The Province operates the Nova Scotia Training School for severely mentally retarded children.

Deaf children go to the interprovincial School for the Deaf in Amherst. Blind children attend the Halifax School for the Blind.

For arthritis and rheumatism, the Canadian Arthritis and Rheumatism Society, Nova Scotia Division, sponsors treatment in four centres and mobile physiotherapy units in three others. An arthritis clinic is held in Halifax.

The Canadian National Institute for the Blind has field secretaries in several areas providing local services. A glaucoma clinic is provided at the Victoria General Hospital.

In mental retardation, assessment is carried out by five community mental health clinics and by a psychologist employed by the Department of Public Welfare. The Nova Scotia Association for Retarded Children through its eight branches provides certain education services.

The Nova Scotia Rehabilitation Centre provides long-term care of paraplegics and hemiplegics. The Canadian Paraplegic Association, Nova Scotia Division, employs a rehabilitation officer.

The Canadian Foundation for Poliomyelitis, Nova Scotia Chapter, provides a variety of supplementary services to ex-polio and the adult disabled. It has a sheltered work-shop jointly with the Junior League in Halifax.

Other groups concerned with rehabilitation include the Tuberculosis Association, Canadian Mental Health Association, Cerebral Palsy Association, Cystic Fibrosis Foundation, Canadian Red Cross, and service clubs.

Home Care

A home nursing care plan is operated in Nova Scotia in areas served by the Victorian Order of Nurses. However, the public health nurses will give home care in emergencies. The public health nurses also instruct persons in the home so that they can cope with nursing problems.

Welfare Programmes

The Department of Public Welfare administers the categorical allowances and Mothers' Allowances. Social assistance is administered by municipalities which receive reimbursement from the Department for two-thirds of the costs of assistance and one-half of the cost of administration.

The aged are cared for in municipal or county homes, in homes operated by religious or private organizations and in private boarding homes. The Province reimburses the municipality for two-thirds of the expenditures for the maintenance of needy persons in municipal homes subject to compliance with specified standards of care and accommodation. Homes for the aged receiving aid from the Provincial Government are subject to provincial inspection.

Child Welfare services, including unmarried mothers and adoption, are administered by local children's aid societies in heavily populated areas and by the Province in other areas. Maintenance costs for children in care of a voluntary or public agency are borne partly by the municipality of residence and partly by the Province.

Nova Scotia has a programme covering Mothers' Allowance recipients, their dependents and Blindness Allowance recipients for medical services on a means test basis. It provides major and minor surgical and obstetrical services and medical attendance in hospital. The indigent medical care programme is operated under an agreement between the Province and the medical society on presentation of an identification card. The Province pays a monthly amount on behalf of all beneficiaries to a fund administered by Maritime Medical Care for the Medical Society of Nova Scotia. The accounts are pro-rated on the basis of available money for payment. All other public assistance recipients, including those on relief, receive necessary care at local discretion from the municipality of residence. Care of transients or medical indigents without residence is a provincial responsibility.

Local Children's Aid Societies may set up a medical trust fund and pay into it for each child ward. The individual society, in co-operation with the local medical society, administers the plan, covering health services exclusive of hospital care.

Provincial Comments

One of our referees writes:

"I believe it is important to emphasize, that conditions in other parts of Canada are far from the Ontario situation...Similarly, in Ontario, as you know, titles do not

have the same significance. Looking at the chart of the Ontario Department of Health one would ordinarily believe that the Director of Public Health Nurses should have a staff of Public Health Nurses throughout the Province, whereas it would appear in actual fact that the Director of Public Health Nurses is only a Consultant to Municipal Health Units. I could go on to enumerate other differences but I am sure that I do not need to bring these to your attention.

"We are, of course, most emphatically in agreement with your suggestion that public health should be dealt with through regional health units. However, such regional health units are almost useless unless there is a strong provincial component to ensure uniform policies, salaries, etc. The most important component in order to obtain this situation is, of course, financial. If the various parts of the Province were to be left alone to develop regional health units without provincial leadership and financial support, I doubt if there would be much improvement. Despite what we may say regarding the weakness of uniformity, in general there is much to be said for a uniform health program on a provincial level, since disease does not seem to worry about health units or municipal borders.

"I am, of course, in agreement with your suggestion that cities and large towns should develop their own health units, and here again, there is need to tie this in with a province-wide program, and again, the only component that seems to work in this situation, is financial assistance tied in, of course, with policy statements to which all units must agree before assistance is given.

"I realize that Ontario thinking is almost entirely based on the concept that local authorities must have a large hand in the local program. However, I am biased on this matter since we feel we have a satisfactory public health program with only minimal local representation, that is, the Municipal Boards of Health. We are going to attempt to make such Boards take more interest in the program. . ."

Another writes:

"Most of the difficulties you mention would, I consider, be applicable to nearly all Canadian provinces.

"As a basic step, I consider that the most effective public health programme is one administered under provincial acts by provincial civil servants who receive their full pay from the Provincial Treasury. In this area, we have had very indifferent results insofar as local Boards of Health were concerned. A few towns passed some regulations, however, the overall picture in this respect has not been too good. Local Boards of Health proved very reluctant to enforce regulations. An amended and consolidated Public Health Act (received assent on April 13th, 1962) was a very important contribution to public health in Nova Scotia. Many of our sanitary problems were satisfactorily covered in this Act. In addition, District Boards of Health were abolished to be replaced by Municipal Boards of Health. The Health Unit Director is the Medical Health Officer and Executive Officer of each Municipal Board. Municipal Boards of Health can appoint an additional part or full time Medical Health Officer if they so desire. In my present capacity I can now deal directly with sanitary nuisances rather than be subject to the frustration of attempting to work through District Boards of Health in a consultative capacity. The intent of the legislation is that a majority (but not all) of the Municipal Board members shall be members of the council that appointed them. Several of our councils have decided this year only to appoint council members to their respective Boards of Health. It has been my definite impression on talking to various municipal clerks that they do not wish non-elected representatives on their boards. I point out the above to show that we have a long way to go in my area before we can establish interested health minded Municipal Boards of Health. It would appear that they are now so financially involved in spiralling education costs that they have little interest or money for any particular health programme.

"In many respects our programme has done well. We have a Dental Hygienist who has been very well received. A Mental Health Centre was established last year to serve this zone. Our tuberculosis control programme has been very successful. Venereal disease has been kept at a low level, and I must say that confidential reporting of cases and contacts by physicians has been carried out reasonably well. I consider this is due in part to a good working relationship between myself and the local members of the medical profession. The past few years has seen modification of our school health programme. We have been using a Certified Nursing Assistant for school vision and audiometric testing, etc. I expect we shall soon see the day when the Public Health Nurse's time in the school will be chiefly devoted to counselling. I might add that the certified nursing assistant renders valuable assistance at immunization and tuberculosis clinics and she also carries out some home visiting under the supervision of the Public Health Nurse. Such visits as 'prenatal' are, of course, only made by the last mentioned.

"I feel that we are carrying out a reasonably good child and maternal health programme, however, like many areas the newborn homes are not being visited early enough. We have yet to develop an in-hospital programme to overcome this deficiency. There are two new nurses' offices in hospitals either being planned or under construction. This will give us an 'in' which we must utilize to the fullest extent. Our nurses still feel that they are not receiving an adequate number of referrals from doctors with particular reference to prenatal classes as well as special home problems. To sum up, an effective programme in maternal and child health must depend upon the establishment of a good working relationship with doctors and hospitals. My Nursing Supervisor and I would envisage a public health nurse visiting each hospital routinely with the full support of the hospital staff to obtain first hand information with regard to those cases with special home problems as well as those who need early visits. I further consider that the public health nurse will enjoy a much more effective relationship with physicians once we embark on a generalized nursing service (to include a modified bedside nursing programme). Before any final consideration is given to the latter development, it is considered that the certified nursing assistant must be fully integrated into the work of our Health Units.

"The Nova Scotia Hospital Commission has zoned this province into nine hospital districts. This Health Unit has three hospitals with one full-time radiologist employed. It is anticipated that a full time pathologist will also be employed as soon as new construction is completed. One of our greatest needs at the present time is the services of an eye, ear, nose and throat specialist.

"The Co-Ordinator of Rehabilitation is an employee of the Department of Public Health so no difficulties arise as regards that aspect of health services. We also enjoy good liaison with the Children's Aid Societies.

"The suggestion of a regional health service organization to draw together the hospitals, Public Health Department, rehabilitation services and home care services is a very provocative one. Ideally, it is no doubt the answer.

"I would make the following summation:

1. It is my opinion that the most effective public health programme is one administered under provincial legislation by provincial civil servants who receive full compensation from the Provincial Treasury.
2. Efforts must be continued to create more interest in health programming at 'local' levels.
3. Closer liaison must, in the first instance, be established between health departments and hospitals. The various Provincial Hospital Commissions would be of great assistance as regards the development of same.
4. The services of the Certified Nursing Assistant must be fully integrated in public health programmes as soon as possible. The shortage of Public Health Nurses persists.

5. The Health Unit should provide a generalized nursing service. This would, I feel, also ensure a more effective working relationship with the medical profession.
6. We should plan for some type of regional health services organization."

A third correspondent replied,

"Medical Staff in Hospitals

"Undoubtedly there should be co-ordination and co-operation between hospital authorities and departments of health at all levels. This is quite essential.

"In this Province we have developed what we believe to be the maximum co-operation having in mind that hospital matters are administered by Commission which is completely separate from the Department of Public Health.

"I would emphasize that it is quite possible and indeed very practical to have close liaison and co-operation between the Department of Public Health and the so-called independent Commission.

"I cannot say that lack of qualified specialists outside larger centres is posing a problem. As a matter of fact we do have a fair number of specialists particularly surgeons in our smaller urban centres. Lately too there have been a number of internists go out. Pediatricians are still somewhat scarce.

"I have not checked up lately but a few years ago Nova Scotia led Canada in the percentage of hospitals accredited. This was done although we had a large number of small hospitals. I don't think that it is at all impossible, indeed very difficult for a hospital to become accredited even though it is rather small.

"In this Province we have a regional hospital pattern and we find that because of this and other factors, specialists are being attracted to the regional hospitals.

"For the specialist, there is real merit in the idea of a retainer plus fee for service. We have this setup for radiologists and pathologists. Certainly we can and should only expect to have specialists in regional hospitals. What we need primarily are well trained job practitioners in our local hospitals, that is hospitals that are satellites to the regional hospital. Of course, we also need well qualified job practitioners in our regional centres.

"Nursing Staff in Hospitals

"It is our experience that there is still a need for more nurses with specific formal training for supervisory and training school positions. Certainly, training schools should only be in association with the regional hospitals. It is our opinion that the training of Certified Nursing Assistants should be continued and be increased.

"Undoubtedly, the greatest difficulty in obtaining nurses in the more rural areas is a lack of males and the lack of entertainment. We try to compensate by approving additional isolation pay in such areas but in point of fact it is not a money matter and I doubt whether we accomplished too much by the extra remuneration.

"Other Staff in Hospitals

"It is our policy to locate our psychiatric beds, reactivation units (medical rehabilitation) and regional laboratories in regional hospitals. Accordingly, we find that we are beginning slowly to attract physiotherapists, dietitians, pharmacist, etc. to these hospitals.

"Technicians in Hospitals

"At this time we have a surplus of X-ray Technicians.

"There is some significant shortage of Laboratory Technicians. In this Province all training of hospital personnel is carried out by the Commission. This means that the Commission through the Personnel Education Committee administers the training of

laboratory technicians who will be employed by public hospitals. With the co-operation of the Department of Public Health, we see to it that these trainees receive their six months didactic course in the central laboratories in Halifax. The other 12 months of their course is taken as bench work in selected regional hospitals where there is a pathologist. At this time we are training approximately 60 laboratory technicians for regional hospitals and for the central laboratories.

"We also initiated some years ago a training program leading to the degree of Bachelor of Science in Laboratory Technology. St. Francis Xavier University in Antigonish is putting on this course with the co-operation of the regional hospital in Antigonish, and with assistance from National Health Grants. The Department of Public Health and the Hospital Insurance Commission are co-operating in the joint venture. It is extremely promising.

"Bed Use in Hospitals

"In our Province we find that we have a relative lack of active treatment beds particularly in some areas. There is a lack of long term active treatment beds. We cannot see this lack being overcome for the reason that the Federal Hospital Construction Grant is quite inadequate for our needs. Indeed, this inadequacy of the Federal Hospital Construction Grant is the biggest bottleneck in our overall plan for an integrated and co-ordinated system of hospitals in this Province.

"Another real bottleneck is a lack of nursing home beds. Undoubtedly there is a great need for such beds. We feel that generally speaking they should be under the supervision of the Department of Public Health.

"Homes for the Aged

"I would say that these should be primarily under welfare but there should certainly be liaison with the Department of Public Health.

"Ambulance

"I think the time is definitely coming when we will have to pay more attention to ambulance services. I agree with your overall idea that it is only practical to provide a really broad spectrum of hospital services at the regional hospital level. This means that patients are going to be transferred from local hospitals to regional hospitals or even directly admitted to the regional hospital.

"Home Nursing Care

"I think that this should not be hospital oriented. It should be in the Department of Public Health. Obviously there will have to be a liaison between the local health officer and the hospital. This should be effected through the medical social worker.

"General Comments

"Your 'regional unit' depends on the size and the population of the Province. In Nova Scotia I would visualize one 'region' which would be the Province. This should be quite adequate for population of approximately three quarters of a million.

"I would be against the Hospital Commission becoming part of a larger administrative body. I am a very firm believer in the Commission form of administration for hospitals. The matter of Commission versus Department of Public Health administration was gone over very thoroughly by the Hospital Services Planning Commission. The field was reviewed very thoroughly. Briefs from some 15 organizations and societies were included. Only one came out definitely recommending that the plan be administered by the Department of Public Health.

"Certainly I would be against it, including welfare. In my opinion this would be an attempted over-simplification which would only result in bogged down centralization if not stagnation.

"The concept of regional boards is very interesting. I know what you are after but the time that I have, I have not been able to satisfy myself that you will achieve it with such a large heterogeneous body. I think it would make a good if rather over abundant discussion group, but I can't see much action coming out of it. You might add a small executive group to the organization. Even so what powers would this body have?"

NEW BRUNSWICK

Public Health

Organization

Under the Public Health Act the Province is divided into six health districts each having a district medical health officer employed by the Province. Each district is sub-divided into sub-health districts which are synonymous with county units. Each local sub-health district has a board of health responsible for specified services. The local sub-district board of health is constituted in the following manner. Four members are appointed by municipal town or city councils, one member appointed by the Lieutenant-Governor in Council. Additional members are appointed from towns and cities in proportion to population. There is a permanent secretary of each sub-district board responsible for the clerical and administrative duties as well as acting as registrar of vital statistics. The largest district has four sub-districts with four boards of health. The district medical health officer serves as chairman of each of the four sub-districts' boards. Most districts have two or more sub-districts.

The duties of the boards of health include reporting communicable diseases, environmental sanitation, milk and water supplies, control of communicable diseases and collection of vital statistics. The boards appoint sanitary inspectors, sub-deputy registrars and auxiliary personnel.

The Chief Medical Officer directs the work of the six district medical health officers. The public health nurses come under the supervision of the Director of Public Health Nursing. Notwithstanding the creation of health districts, the greatest responsibility is placed on the provincial authorities. The Province employs medical health officers and nurses while local boards employ other staff.

Sanitation

The provincial Health Department maintains a Sanitary Engineering Division which provide supervision and consultation for the sanitary inspectors in the districts in relation to sewage disposal, stream sanitation, milk pasteurization, water and food supplies. The local sanitary inspectors in the districts carry out the inspections at the local level of water supplies, food handling, and sewage disposal.

Communicable Disease Control

The sub-districts are responsible for the collection of reported communicable diseases and for instituting isolation and quarantine measures as required by legislation. The Department assists district medical officers of health and boards of health with epidemiological problems and supplies essential biological products without charge.

The Communicable Diseases Control Division is responsible for the overall immunization programme. Basic immunization in the first year of life is offered

through the health officers and public health nurses. The programme is continued in the pre-school period and in the school age group.

Venereal Disease Control

There is a venereal disease clinic in Saint John providing free advice, examination and treatment. Elsewhere private physicians provide the service. Free penicillin and similar antibiotics for the treatment of all cases are provided by the Communicable Diseases Control Division. It also makes payments to physicians for the treatment of medically indigent cases. Contact investigation is made in all reported cases with the assistance of the medical health officer and public health nurses in the various districts.

Tuberculosis Control

The nurses assist at ten regular tuberculosis clinics. Patch testing is done on children, home visits are made to patients and contacts. There are 11 diagnostic clinics in appropriate locations conducted by district health officers, by the tuberculosis control division with personnel from sanatoria, and by regional tuberculosis consultants.

In addition, the division has established admission chest X-ray units in 14 hospitals. Mass X-ray surveys are carried out in co-operation with the New Brunswick Tuberculosis Central Registry and Film Development Centre in Saint John. As a step to improving case-finding in the northern section of the Province, a tuberculosis consultant was appointed for that area.

Four sanatoria are in operation, one being provincially owned. All are under the supervision of the Director of Tuberculosis Control as far as treatment is concerned. Treatment is free to all residents.

Medical health officers and public health nurses give a considerable part of their time to tuberculosis work. Mass X-ray surveys and tuberculin tests by district nurses are done in the latter case for school children. Positive reactors are then X-rayed. There is a mobile X-ray van operated jointly by the New Brunswick Tuberculosis Association and the Department of Health. B.C.G. vaccine is provided on a selective basis.

In each sanatorium there is staff available under the Director of Rehabilitation to arrange educational and vocational courses and job placement. This is sponsored by the New Brunswick Tuberculosis Association in co-operation with the Department of Health.

Maternal and Child Health

The Maternal and Child Health Division co-ordinates preventive services and administers a treatment programme, maintains a crippled children's registry, and provides services for crippled children in co-operation with voluntary agencies. This division directs the Nutrition Health Services of the Province and provides consultant and advisory service in nutrition to hospitals, schools and all public health agencies in the Province where problems on nutrition are involved.

Prenatal classes and home visiting are provided by the public health nurses. The Victorian Order of Nurses does home visiting of expectant mothers also. Follow-up visits are made to newborn infants and child conferences are held.

The Department offers assistance in providing equipment and consulting on newer procedures for newborn services in hospitals of local areas. There is also a training and education programme for improved professional staffs in

obstetrical departments. A Junior Rehabilitation Programme for children up to age 19 is provided as part of the maternal and child service.

School Health Service

A study of physical fitness, dental and nutritional status of several hundred children in two rural regional schools was undertaken in 1958 as a co-operative project of the Maternal and Child Health Division, Division of Dental Health, the Physical Education Division of the Department of Education, and the District Medical Health Officers concerned. Public health nurses visit each school in their area at regular intervals to provide consultation services.

School Dental Service

The Dental Division's main function is education and consultation directed to the schools. It has promoted the establishment of dental clinics in Saint John and Moncton and community dental clinics for needy children in six other centres. Dental hygienists work under the Dental Health Director. The community dental clinics provide treatment for needy children from the pre-school to the Grade III class level. The clinics are operated for the Department by arrangement with the local dentists on an arranged fee schedule. The Department also supports the local programmes of the Saint John County Board of Health and the City of Moncton.

Laboratory Services

A Central Provincial Laboratory is located at the Saint John General Hospital and there are regional laboratories at four other centres. They provide bacteriological, biochemical, serological, haematological services as well as tissue pathology, and rhesus factor investigations. Other laboratory services are provided at cost to hospitals and public health agencies.

Under the New Brunswick Hospital Care Insurance Plan, the provincial laboratories provide free-of-charge laboratory services to all insured in-patients, together with certain specified tests to insured out-patients.

Cancer Control

The Cancer Control Division provides free diagnostic services to patients through their physician at any of six diagnostic clinics. It pays medical and surgical fees for hospital in-patients being treated for proved cases. There is free out-patient radiation therapy under certain circumstances. A direct and free service is provided to doctors for the examination of biopsy specimens.

Hospitals and the Hospital Insurance Programme

According to the records of the Department of Health, as of December 31, 1963, there were 39 public general hospitals with a total of 3,608 beds. These hospitals are operated by lay, religious and municipal organizations.

There are two provincial mental hospitals, one at Campbellton with a rated bed capacity of 759, and one at Lancaster with a rated bed capacity of 912. However, there are 1,950 beds set up for use in these two mental hospitals.

There are four institutions operated for the treatment of tuberculosis. These institutions can provide a bed capacity of 569 beds. Two of these hospitals are operated by religious orders, one by a municipality, and one by the provincial Department of Health.

In addition to the above, there are two federal hospitals, one operated by the Department of Veterans Affairs at Lancaster with 400 beds, and one by the Department of National Defence at Camp Gagetown with 50 beds.

The provincial Hospital Services Plan administered by the Hospital Services Division of the Health Department provides payment to hospitals for standard ward care under the Dominion-Provincial Programme.

The Division also provides financial assistance and supervision of construction plans of hospitals and a general consultant service on hospital operations.

Patient benefits under the tax-supported Plan include out-patient basic diagnostic and treatment procedures, specified laboratory procedures and necessary interpretation on behalf of the physician, rehabilitation services in conjunction with physiotherapy, medical rehabilitation, and emergency care. Care of indigents is provided through the municipality of residence and in the case of categorical allowance recipients by the Province.

Mental Health

There are two mental hospitals and five full-time mental health clinics. Patients are seen by referral through practising physicians, public health nurses and voluntary agencies. There is a provincial division of the Canadian Mental Health Association which co-operates with the provincial Health Department in health education and research activities.

Rehabilitation

The Rehabilitation Division provides a comprehensive service to disabled adults as well as vocational counselling, training and employment service in co-operation with the vocational training agencies and the National Employment Service. The Director and Co-ordinator of Rehabilitation who heads the Division works closely with the New Brunswick Tuberculosis Association, the Canadian Foundation for Poliomyelitis and Rehabilitation, New Brunswick Chapter, and the New Brunswick Co-ordinating Council for the Handicapped. This latter represents public and voluntary agencies and co-ordinates their activities to provide such services as transportation, medical care outside the Province, and other ancillary services.

The Hospital Insurance Plan covers in-patient care and specified out-patient services, including physiotherapy, now established in a number of hospitals. Certain out-patient laboratory and X-ray services excluded from the Plan are provided by the Rehabilitation Division. Two general hospitals have social service departments. Rehabilitation services are supplied to adults aged 19 or over who can be restored to employment or self-care. For those under this age, the Junior Rehabilitation Programme of the Maternal and Child Health Division provides care. This includes visual and hearing defects as well.

A poliomyelitis clinic is operated by the Province in Fredericton for children with orthopaedic handicaps. It also includes medical assessment and treatment. Surgery is provided at the adjacent Victoria Public Hospital. The Forest Hill Rehabilitation Centre in Fredericton is a 21-bed centre operated by a voluntary group and includes physical restoration and occupational therapy.

In addition to out-patient clinics by the two centres, the larger hospitals conduct clinics for various diagnostic groups. Prosthetic services are purchased from a commercial firm, the Department of Veterans Affairs, the Poliomyelitis Clinic, and the Forest Hill Centre. Five rehabilitation counsellors are stationed in five areas to provide counselling assessment, medical, vocational and other rehabilitation services. The New Brunswick Tuberculosis Association Councillor works with the Division. Eligibility is restricted to those 19 and over who cannot pay for service but who have some prospect of vocational usefulness. The

Medical Consultant to the Division is the Supervisor of the Forest Hill Rehabilitation Centre. The Division works closely with the National Employment Service.

The Maternal and Child Health Division has an active programme for handicapped children. It works closely with the Poliomyelitis Clinic and the Forest Hill Centre, the co-ordinating Council for the Handicapped, the Rehabilitation Division and other health and welfare agencies

The deaf and blind are cared for at the School for the Deaf at Amherst, and the Halifax School for the blind, both in Nova Scotia.

The Victorian Order of Nurses provides a nursing service in ten communities. The Canadian Arthritis and Rheumatism Society has clinics at the Poliomyelitis Clinic and at the Forest Hill Centre in Fredericton and at St. Joseph's Hospital in Saint John, as well as two mobile physiotherapy clinics. The Canadian National Institute for the Blind provides special eye clinics periodically. Field secretaries are in five larger cities to assist the blind. There is a glaucoma clinic in Saint John. The Cerebral Palsy Association operates special classes in Saint John and Moncton. The Saint John branch of the Canadian Diabetic Association provides certain services. Some local parents' associations for retarded children have provided certain services. The New Brunswick Chapter of the Canadian Foundation for Polio and Rehabilitation provides help to ex-polio patients and disabled adults generally. The New Brunswick Board of the Canadian Paraplegic Association, Maritime Division, has a rehabilitation officer.

Care of the Aged

There is no special health services programme provided for this group of the population in New Brunswick. The Department of Youth and Welfare provides financial assistance to needy individuals for municipal home care under the terms of the Social Assistance Act. Homes for the aged are operated under municipal, religious, and private auspices and receive no direct financial support from the Province. Voluntary and proprietary homes are subject to provincial licensing and inspection and must meet standards contained in the regulations under the Public Health Act.

Welfare Programmes

In addition to Mothers' Allowances the Department of Youth and Welfare shares with the municipalities the costs of the general assistance programme. The Province reimburses each municipality to the extent of \$1.00 *per capita* of the population plus 70 per cent of the expenditures on general assistance in excess of that amount and also pays 50 per cent of the cost of administration. It supervises the municipal programmes as well.

Child welfare, adoption, and unmarried mothers' services are administered through a network of local Children's Aid Societies operating under statutory authority. Maintenance costs for children in care of a voluntary or public agency are borne partly by the municipality of residence and partly by the Province.

QUEBEC

Public Health

Organization

HEALTH UNITS

Except for the City of Quebec and the Montreal regions, local public health services are provided through 73 health units organized on a county or multi-county basis. The units depend directly on the provincial Ministry of Health. Their programmes are planned centrally, and their personnel is appointed by the Province. However, the unit directors are free to use initiative in meeting local problems. The operating cost of these units is met by the Ministry of Health. About 10 per cent of it is reimbursed by the municipalities through a special property tax.

Each unit has a full-time medical health officer and, where needed, assistant medical health officers on full- or part-time basis. Other staff members include, health nurses, tuberculosis clinicians, dentists, veterinarians, sanitary inspectors, technical personnel, and clerical staff. The health unit programmes include public health nursing, maternal and child health, school health, tuberculosis clinics, sanitation, nutrition, dental health, mental health, communicable diseases control, and health education services. Each unit has modern X-ray facilities.

The health units have been grouped in eight districts for administrative purposes.

MUNICIPAL HEALTH DEPARTMENTS

The cities of Quebec, Montreal, Westmount, Outremont, Montreal North, and Verdun and the Town of Mount Royal have their own full-time municipal health departments. As of the end of February 1963, seven other municipalities in the Montreal area had municipal departments with part-time medical health officers. The municipal boards of health composed of town councillors function in an advisory relationship to the health departments and municipal authorities but have no executive powers. Executive power is vested in the health officers. The municipal clerk-treasurer or city manager in practice also makes decisions on behalf of the municipal authorities.

With small exceptions, municipal health department revenues come from general municipal tax funds except for some assistance through the dominion-provincial Health Grants and the provision of certain biologicals by the Province.

The Province maintains general supervisory powers over the municipal departments, chiefly in epidemiology, communicable diseases control, water supplies, sewage disposal, and the elimination of nuisance. It also provides consultant services in such fields as maternal and child health, mental hygiene, nutrition, health education and sanitation.

HEALTH SERVICES IN REMOTE SETTLEMENTS

The provincial Ministry of Health provides a special service to settlements in remote, isolated, non-municipally organized territories. One public health nurse is stationed in each settlement to provide public health nursing services, as well

as emergency medical care and obstetrics. The nurse receives direction from the nearest practising physician who provides part-time medical and public health services on a fee-for-service basis.

Sanitation

The sanitary inspectors of health units are concerned with environment sanitation, including the sanitary production of milk on farms and the handling in dairies, supervision of dumps, slaughter houses, restaurants, schools, sewage disposal, and waterworks systems. The Sanitary Engineering Division of the Ministry of Health has complete jurisdiction over waterworks, water filtration plants, and the sanitation of public baths. A staff of special inspectors, under a professional engineer, works closely with the sanitary inspectors in the health units and health departments for the control of pasteurization plants. The routine inspection of restaurants and other aspects of sanitary inspection are the responsibility of the health units and health departments.

Communicable Disease Control

Notifiable communicable diseases are reported by health units and city health departments to the Ministry. The Ministry carries out epidemiological investigations, examination of contacts and suspected cases, home and school visits and immunization programmes. The health units and departments distribute biological products for the prevention and, in some cases, treatment of communicable diseases, which are provided free of charge by the Province. Isolation and quarantine measures as indicated by the provincial regulations are implemented locally.

The Division of Epidemiology is entrusted with the study of disease in general and with the surveillance of communicable disease. Cases are notified by the health units to the Ministry. The Division is responsible for the collection and preparation of information, the compilation of statistics, and for the immunization status of the Province as a whole. It also provides direction and consultative services to the health units and directs applied research in the field of public health.

Laboratory Services

There are three main sections to the Provincial Laboratory, the Laboratory of Diagnostic Microbiology, the Laboratory of Chemistry and Sanitation, and the Laboratory of Serology.

Tuberculosis Control

Early steps were taken by private organizations to set up special diagnostic facilities in larger cities. Subsequent organization of wide-scale X-ray surveys was undertaken by anti-tuberculosis leagues working independently or in association with the health units. A Provincial Committee for the Prevention of Tuberculosis, a voluntary co-ordinating body similar to branches of the Canadian Tuberculosis Association in other provinces, co-operates with the Ministry of Health in promoting case-finding, mass surveys, and an education programme. The Committee organizes the Christmas Seal campaigns except in Montreal and Quebec, where anti-tuberculosis leagues conduct their own. They report their financial results to the Provincial Committee.

Special responsibilities of the Ministry include general supervision over all anti-tuberculosis programmes, maintenance of a central case register,

appointment of medical directors for sanatoria, and supervision of anti-tuberculosis programmes in the health units. B.C.G. vaccine is used extensively by public health and hospital personnel. From 1945-1956 the percentage of newborn infants vaccinated rose to 40 per cent. A central register keeps an up-to-date record of B.C.G. vaccinations and of the 1,800,000 cases of tuberculosis diagnosed since 1927.

The anti-tuberculosis out-patient clinics in the larger cities are staffed and equipped to provide consultation and complete out-patient diagnostic services for tuberculosis and other thoracic diseases. These are maintained by anti-tuberculosis leagues, in close co-operation with the health units. Besides clinical work, they provide medical, social service, and nursing personnel for finding and examining contacts, supervising the administration of drugs to ambulatory patients, and maintaining contact with people with a previous history of tuberculosis.

Outside the major cities, the responsibility for case-finding rests with the sanatoria, the health units, and anti-tuberculosis leagues. X-ray surveys are widely employed through the units. Mobile units well equipped for diagnostic and consultative clinics with clinicians in tuberculosis, nurses, and technicians, travel extensively throughout the Province. Programmes are defined in collaboration with the district medical officers. These are found to be the most successful methods in rural areas.

There is growing use of thoracic out-patient clinics in general hospitals for the examination of persons with chest disorders, including tuberculosis. Special diagnostic equipment has been made available through the health grants to assist thoracic clinics in several hospitals in the Province.

A provincial survey is being carried out to improve the effectiveness of the mobile, semi-mobile, and permanent centres of tuberculosis control. It is being done through the district health medical officers, directors of sanatoria, and the Director of Tuberculosis Control for the Province.

Venereal Disease Control

The reporting and treatment of venereal diseases is compulsory. Health education is stressed. Attempts are made by the Venereal Disease Control Division to investigate and supervise contacts. A number of out-patient departments in various general hospitals provide free examination, diagnosis, and treatment. These are subsidized by the Province. The Division distributes antibiotics and drugs to clinics and private physicians free of charge for the treatment of patients. Doctors are also reimbursed for the treatment of indigent patients.

Maternal and Child Health

The Maternal and Child Health Division is concerned with the maintenance and improvement of health of mothers and children throughout the Province. Close co-operation and liaison exist with other services who share interest in the care of mothers and children, such as the Division of County Health Units, the Division of Epidemiology, and the Division of Health Education. Broadly speaking, the Maternal and Child Health Division provides consulting services to local health services in the fields of maternal and child health, such as the prenatal programme, and to the Hospital Insurance Service. The Nursing Consultant routinely visits nurseries and delivery rooms of all public general hospitals and provides information and advice to nursing staff on techniques of care for mothers and their newborn infants.

Staff training is a most important feature of the programme. In 1955, this Division in co-operation with the Department of Pediatrics of Sainte Justine Hospital and of the Royal Victoria Hospital, organized a series of eight-week post-graduate courses for nurses on the care of newborn and particularly premature infants; in addition, these nurses are given a four-week theoretical and practical course in hospital asepsis technique at Sainte-Justine or Montreal Children's Hospital. The Ministry of Health also contributed to the organization of the Institut Marguerite d'Youville's eight-month post-graduate courses in Pediatric and Obstetric nursing.

Finally, the Ministry of Health has organized Poison Control Centres all over the Province and continues to supervise this programme.

Nutrition

This Division is responsible for the scientific direction of teaching in nutrition through the Province. Most of the teaching and educating is done by the public health nurses of the county health units and the nutritionists of the Division teach nutrition to the public health nurses, train them in their nutrition work, and keep them informed of scientific developments in the field of nutrition. From time to time, the Nutrition Division organizes refresher courses for nurses recently appointed as public health nurses. After they have graduated from the School of Hygiene, the public health nurses are called by groups of eight or ten for a two-week workshop, during which they are trained to fulfil their duties as educators of the public in nutrition.

The Nutrition Division prepares and distributes teaching material and other special publications which are not already distributed by the Federal Division of Nutrition.

Health Education

Health education is an essential part of the general programme, both at the provincial and local levels. Educational activities at the local level are shared by the medical health officer and all of his staff and involve the family, the school, and the community. The local health officer and his staff, the school board, and the teaching personnel execute a programme planned by the health unit, which is particularly centred on the health examination of children.

At the provincial level, the Health Education Division, in close co-operation with other services of the Ministry, carries on three main functions: 1) production and distribution of educational material (printed material, posters, films, radio and television material), 2) technical assistance in all matters concerning material and methods of health education, group dynamics and the mass media, 3) public relations with government services and voluntary agencies interested or likely to be interested in health education.

Dental Health Service

This is administered by a Division through the health unit programme. Sixty-one units have a dentist whose functions include dental health education, prophylaxis, and preventive treatments. These dentists devote about one-half day per week to the treatment of indigent patients. Forty-seven dental clinics are fully equipped. Fourteen dentists are presently employed on a full-time basis and others are to be appointed. Some 47 dentists serve part time.

Mental Health

The Division of Psychiatric Hospitals was replaced in 1962 by that of Psychiatric Services. The programme objectives are:

- to promote professional training by a financial assistance;
- to regionalize the treatment and rehabilitation services;
- to increase financial assistance to psychiatric hospitals in accordance with the needs of the patients;
- to develop psychiatric services in general hospitals;
- to create services encompassing all different needs, including child psychiatric services, foster-homes, and half-way houses.

The Province of Quebec has 18 psychiatric hospitals, of which two are for epileptics. Three of these are the property of the Quebec Government. One is owned by the Federal Department of Veterans Affairs. All the others are public hospitals. Twenty-four general hospitals have psychiatric out-patient clinics. Some have day- and/or night-care services. Eleven of them also have an in-patient psychiatric service. There are, moreover, in the Province 14 mental hygiene clinics, and one general hospital in Montreal which provides home-care services. Finally, the Canadian Mental Health Association, Quebec Division, has a number of branches.

Rehabilitation

There are numerous medical-social agencies devoted to the rehabilitation of handicapped people.¹ For the most part, the role of the Province has been to subsidize the agencies for treatment, education, and care of the handicapped. Exceptions are the Workmen's Compensation Board Rehabilitation Service, the Ministry of Youth Vocational Rehabilitation Service for the tuberculous and other physically handicapped, and the Special Placement Service of the Provincial Employment Service.

Community councils, for example the Montreal Council of Social Agencies, are also concerned with social planning and co-ordination of services.

Extensive restorative services are available at the university teaching hospitals in Montreal and Quebec and at a number of other large hospitals. All residents of the Province are automatically covered under the Hospital Services Plan. Public assistance recipients, welfare cases, and other persons unable to pay for medical care are treated without charge at the wide variety of hospital out-patient clinics and dispensaries. A number of the general hospitals, children's hospitals, and chronic hospitals have physiotherapy services. Occupational therapy services exist in a few hospitals. A number of hospitals, general hospitals, children's hospitals, chronic hospitals and other hospitals have physical therapy departments.

The Rehabilitation Institute of Montreal provides comprehensive services including orthopedic, neurological, psychiatric, prosthetic, medical-social service, etc. It is used as a teaching and research centre by the University of Montreal.

The Occupational Therapy and Rehabilitation Centre of Montreal has an out-patient centre affording a variety of services, physical and occupational,

¹ List of Canadian Hospitals and Related Institutions and Facilities, 1962, Ottawa: Dominion Bureau of Statistics, Health and Welfare Division, 1962.

speech therapy, social case work, psychological and vocational training. It is used by McGill University for training and is a member of the Welfare Federation and United Fund. The in-patients' service has been covered under hospital insurance as of April 1962.

The Quebec Rehabilitation Clinic Incorporated provides comprehensive service to physically handicapped children and adults at an out-patient centre and a 40-bed rehabilitation unit at Laval Hospital. Some cases are referred by the Workmen's Compensation Board which pays for services. Other sources include federal-provincial grants, private patients, the Quebec Chapter of the Canadian Foundation for Poliomyelitis and Rehabilitation, and the Quebec Rotary Club.

The Rehabilitation Clinic for handicapped children at Three Rivers has an out-patient service for the St. Maurice Valley region offering a wide variety of services.

The Workmen's Compensation Centre, Quebec, has a new centre to accommodate 250 injured workmen. A small out-patient clinic is operated in Montreal. The services of the physical medicine department of the general hospitals are also used.

Prosthetic services have been set up at the Rehabilitation Institute of Montreal, Quebec Rehabilitation Clinic, and the Hotel-Dieu Hospital in Chicoutimi. There are boot shops at Sainte-Justine and the Shriners Hospital in Montreal. The Ministry of Health pays 50 per cent of the cost of prosthetic appliances and personal aids. Voluntary agencies, such as the Quebec Society for Crippled Children and the Foundation for Poliomyelitis and Rehabilitation, contribute the remaining half of the costs, in certain cases. The latter organization also has a wheel-chair and health equipment pool from which items are loaned.

The Physically Handicapped Division of the Ministry of Youth conducts a Vocational Rehabilitation Programme for tuberculosis patients and other handicapped persons. It operates training centres at four sanatoria and makes special provision for the handicapped to attend provincial guidance bureaus under the "Conseil d'orientation des handicapés de Montréal", which also gives vocational counselling to the handicapped. Several rehabilitation officers posted in Montreal and Quebec offer vocational counselling and assist clients. Effective April 1, 1961, Quebec has been a party to the federal-provincial provision for training disabled persons under the Technical and Vocational Training Assistance Act on a 50:50 sharing cost basis. The Ministry of Youth has used this extensively. The National Employment Service and the Provincial Employment Service operate special sections for special job placement of the handicapped through their district offices. In Montreal, there are a number of sheltered workshops. Recreational services are also provided.

For handicapped children, there are medical services at several hospitals, three children's hospitals and several rehabilitation centres. The Quebec Society for Crippled Children, mainly in the Montreal area, provides transportation, treatment centres, appliances, and a camp. Many other organizations include the Cerebral Palsy Association of Quebec, the Canadian National Institute for the Blind, and the Junior Red Cross. Special educational facilities have been operated by the Protestant and the Roman Catholic Schools Committees, such as special schools and auxiliary classes.

The Canadian Arthritis and Rheumatism Society operates a number of mobile physiotherapy units in Montreal and Quebec serving patients confined to their home. Free service is provided if patients are unable to pay.

A variety of agencies, both English and French, serve the blind. Ophthalmology clinics are held at teaching and larger hospitals in Quebec and Montreal. Glaucoma clinics are held in Montreal, Sherbrooke, Chicoutimi, Hull, and Quebec hospitals. The Canadian National Institute for the Blind, through its 16 branches, provides a comprehensive programme of blindness prevention, social education, and employment services. The Montreal Association for the Blind and the French-Canadian Association for the Blind operate workshops. Education and training of blind children is provided by three special schools.

Special programmes for cerebral palsy patients are conducted at the Sainte-Justine Hospital in Montreal and at the Montreal Children's Hospital. Other hospitals also provide services. The Quebec Society for Crippled Children and the Cerebral Palsy Association of Quebec provide transportation, equipment, braces, summer camps, etc.

Hearing tests are done by local health units equipped with audiometers. The provincial Ministry operates a mobile blindness and deafness clinic, in co-ordination with the health units. This unit also serves other groups such as college students and industrial workers. Special therapy clinics are located in Montreal at a number of hospitals and elsewhere in the Province. Several schools provide vocational training.

Special agencies for the treatment and rehabilitation of alcoholics are subsidized by the Ministry of Health. They are located in Montreal, Quebec, St. Jérôme, Three Rivers, and Sherbrooke, and numerous other cities. These centres maintain a certain number of beds for the acute cases and for intensive therapy. The Department of Health of the City of Montreal runs a rehabilitation centre.

For arthritics, some hospitals have special units, while others hold regular out-patient clinics. The Ministry of Family and Social Welfare has built a new school for deaf-mute boys near Quebec.

A variety of services are available for epilepsy, haemophilia, paraplegia, and polio.

Home Care

Organized home care programmes furnishing medical, nursing, social services and other related services, such as physiotherapy and homemakers' services, are conducted by the Reddy Memorial Hospital and the Hospital Ste. Jeanne D'Arc, both in Montreal. Home nursing care to the handicapped and the chronically ill is furnished in larger cities by the V.O.N. and the "Société des infirmières visiteuses", Montreal. Physiotherapy treatment to patients at home is supplied by the Canadian Arthritis and Rheumatism Society and, recently, by the Canadian Foundation for Poliomyelitis and Rehabilitation in a rural county. Homemaker service is provided by the Montreal Family Service Association.

Hospitals and the Hospital Insurance Programme

The 1962 Canadian Hospital Directory lists the following public hospital facilities for the Province of Quebec:

Institutions	Beds	Chronic	Contagious	Convalescent	General	Mental	Orthopaedic	Tuberculosis
177	52,152	4,414	510	520	22,346	20,920	455	2,987

These are all public hospitals operated by lay, religious, municipal or provincial auspices.

There were also 74 private hospitals with 1,804 beds, of which 637 were for chronically ill, 19 convalescent, 1,083 for general use, 40 for mentally ill, and 25 for tuberculosis patients.

The various departments of the Dominion Government operate 14 hospitals in Quebec. The Department of Veterans Affairs has five with 2,163 beds, of which 364 are for chronic, 1,103 for general, 578 for mental, and 118 for tuberculosis patients. The Department of National Health and Welfare operates eight hospitals with 89 beds for Indians. It also has a hospital at Quebec with 29 beds for immigrants with communicable diseases.

The Hospital Insurance Programme is administered by the Hospital Insurance Division of the Ministry of Health and is financed out of general tax revenues. Standard in-patient services, free emergency treatment, free minor surgery, and out-patient clinics without charge, except for professional fees, are covered. Psychiatric care in general hospitals is also covered.

Medical and other health services are available to indigents through a wide variety of dispensaries. A nominal charge may be made but, in general, costs of care are borne by the agency providing the service. This agency may, in turn, be supported by public funds. In all areas without such facilities, service is given by the local doctor, dentist, or other person providing services through private arrangement with the patient or with the municipality.

Welfare Programmes

The provincial Ministry of Social Welfare reimburses municipal departments or authorized agencies for the full cost of aid to persons in their own homes, and administers aid for persons who are unfit to work for at least 12 months. Since September 1961, supplementary allowances to needy recipients of Government benefits and allowances to needy widows and spinsters, 60 to 65 years of age, have been provided. The cost of aid to unemployable persons in homes for special care, including nursing homes, is borne according to the following ratio: two-thirds by the Province and one-third by the institution.

Institutional care for indigent old people in Quebec is provided through charitable institutions under the Public Charities Act. The Homes for the Aged Act authorized the Province to erect and maintain homes for the aged, to build housing projects, and to make grants to voluntary organizations for this purpose. Standards in homes are governed by regulations under the Public Health Act.

Child Welfare services, including services to unmarried mothers, and adoption, are administrated by recognized voluntary agencies and institutions.

Children's Aid Societies and the other recognized agencies in Quebec receive substantial provincial grants and some municipal grants. Mothers' Allowances are also provided. In many areas, they also receive support from private subscriptions and community chests or united funds.

Provincial Comments

Differences in patterns of services between Quebec and Ontario were emphasized by several of those to whom referral was made. One person strongly

recommended the advisability of studies being made in due course in each province.

Another writes:

"We are aware of deficiencies in our activities, but know they are due to an acute lack of personnel. This is the most important problem at this moment—an increase in the (salary) scale would not, however, solve the problem once and for all. Hospitals offer better salaries than we do and yet they are short of staff. In addition, this problem will always be acute in rural regions. In relation to sanitary inspectors, a better choice with basic qualifications—age—instruction and personality—would help in permitting a specialization of candidates, somewhat equivalent to the English Sanitarians. Part-time personnel do not give satisfaction and there is a definite tendency in this Department to retain the services of a strict minimum of part-time staff without injuring the organization."

Another correspondent writes on several subjects:

"Organization"

"In the province of Quebec, except for the Montreal region and the City of Quebec, all municipalities depend on the provincial Ministry of Health through the health units for services. Therefore, the municipalities have no direct responsibilities for public health services except for paying the Provincial Government a certain amount of money every year. This has the disadvantage that municipal authorities are not concerned directly and personally with public health services and they have no authority over the personnel of the health units. Consequently, the contact between the personnel of health units and the members of municipal councils are generally limited especially if the office of the health unit is not located in a particular municipality. On the other hand, the personnel of a health unit restrict their executive powers (especially in sanitation and inspection) in order to prevent friction with municipal authorities.

"Some municipalities (restricted to the Montreal region and the City of Quebec) have their own Health Departments. Their standards vary to a great extent. In these municipalities the boards of health are usually composed of more or less interested municipal councillors. The municipal clerk-treasurer or city manager is in fact the person who makes many decisions. Some municipal administrators believe that health services are a provincial responsibility. This point of view is a factor when budgets are being presented.

"It would be advisable to define what is federal, provincial, and municipal responsibility."

"Staffing"

"At the present time, there are shortages of public health personnel at the level of the health units and the level of municipal health services. It is felt that trained personnel could be used to greater advantage.

"There is relative isolation of the public health doctor from his confreres and his work tends to be restricted to immunization with some consultations in well-baby clinics and in schools. Inoculation is a routine procedure that could be assumed by trained technicians or nurses. The consultations have their interest but remain theoretical since the doctor does not assume any clinical responsibilities. For the future we should think of the medical health officer either as an administrator concerned with community health services, including the hospital, or as a specialist in some specific branches but connected with the clinical field. As for the routine physical examination in schools and in the well-baby clinics, there is no need to have a public health doctor do them. A more liberal use of practising doctors is important since this will increase the army of 'those who prevent'. Self-respect by the public health profession is a goal to be achieved.

"This problem is not as acute with the public health nurse who accepts more readily the restriction of her work to prevention and education. But in rural areas, bedside service should be provided by the public health nurse because this service does not exist everywhere otherwise.

"In order to obey 'la loi de l'offre et de la demande' and since you get what you pay for, incomes should be adequate."

Financing

"At the level of health units, no figures are available in the Annual Report of the Ministry of Health on per capita expenditures. Budgets are always presented as a whole and include hospitalization, which takes a major part.

"The municipal health services are greatly influenced by their budgets. Some municipalities have only part-time staff and some others have a more complex health organization. As the budget is voted by city councils, the basic point is to state once and for all what are the municipal responsibilities in public health. Furthermore, provincial authorities should help financially those municipalities which wish to organize an adequate health service. It is suggested that the provincial Ministry of Health see that an accreditation is done. This is done at the hospital level, why not with the public health services?"

Programme

"On the whole your remarks on statutory services can be applied to the Province of Quebec. May I insist, though, on the two most acute problems: dental health and mental health. In these two fields, facilities are inadequate in rural and urban regions.

"Chronic diseases and the care of the aged are major problems too, but, so far, measures concerning these categories of people remain the responsibility of voluntary organizations."

MANITOBA

Public Health

Organization

GENERAL

Provincial health services are provided through three main Divisions of Health Services, Psychiatric Services, and Rehabilitation Services in the Department of Health and through several other quasi-government or voluntary agencies subsidized by government funds. All these public health and personal health care services have been developed in close co-operation with local authorities. The Division of Health Services contains five sections: Environmental Sanitation, Preventive Medical Services, Extension Health Services, Public Health Nursing Services, and Laboratory Services. The Psychiatric Services Division includes sections of Hospital Services and Community Mental Health Services. The Division of Rehabilitation Services co-ordinates the federal programmes and the work of the major rehabilitation agencies.

Semi-official boards and organizations include the Sanatorium Board of Manitoba, the Manitoba Cancer Treatment and Research Foundation, the Manitoba Society for Crippled Children and Adults, the Alcohol Research and Rehabilitation Foundation.

The Manitoba Health Plan provides for the division of the Province into four large regions with subdivision into smaller districts for local administration. By

the end of 1962, 14 local health units had been established. These served 73 rural municipalities and 31 towns and cities. Excluding Winnipeg these units provide full-time health services to almost 75 per cent of the population of the Province. Local health units are established on approval of municipal councils and are operated and financed jointly by the provincial government and local authorities. The staff is employed and paid by the provincial Department of Health.

The staff of each unit consists of the medical director, and depending on size, from three to 12 public health nurses, one to four sanitary inspectors and clerical personnel, as well as a part-time public health educator. Each unit has an advisory board which exercises general supervision over the operation of the unit, is responsible for local policy, and may recommend to the Minister improvements or extension of services.

Under the Manitoba Public Health Act and Regulations, each municipality in organized territory which is not included in a health unit must employ a physician to act as medical officer of health, either on a part-time or full-time basis, and provide basic services. The provincial Public Health Nursing Service Section provides several public health nurses for areas outside health units. The Division of Environmental Sanitation has a staff of Public Health inspectors located in the areas of the Province not served by units.

CITY OF WINNIPEG

The City of Winnipeg Health Department operates autonomously. It reports to the Health and Welfare Committee of Council, consisting of the mayor and six aldermen. The Health Officer reports to the Committee but is not a member of it. Committee meetings are open. There are also a full-time deputy health officer and part-time assistant health officers. The City Department attracts a good standard of public health nurse and keeps a standard of over 80 per cent with public health certificates by reaching an understanding that they will take courses as soon as possible after joining the staff. The Inspections Branch operates a specialized service in four divisions, each under a Principal Inspector reporting through a Chief Health Inspector to the Health Officer, although informal lines of communication are quite free. Both the Chief Health Inspector and the Principal Food Inspector are Doctors of Veterinary Medicine but have no formal public health training. The Dairy Division inspects and licenses all dairies in the Metropolitan Winnipeg Milk Shed. They also are responsible for inspection and licensing of all milk plants selling their products in the Winnipeg area, even though two of these are in St. Boniface. The other Divisions are Housing and Sanitation. The latter is largely concerned with factories and workshops, and general public nuisances.

The City Health Department operates a full programme. The Health Officer, Deputy, all Inspection Services, Director of Nursing, Tuberculosis Control, Nursing Home Program, and all care services operate out of the headquarters office in the City Hall. The public health nurses operate from four district offices. All school physicians and child health centre physicians are employed on a sessional basis, although several women physicians work five mornings per week in schools. Child health physicians are nearly all certificated pediatricians or residents from the Children's Hospital.

The public health nurses report weekly any unusual incidence of illness in schools, although they may report at any time if the situation warrants. All district offices and larger schools have Hanks solution and swabs for viral and

bacterial specimen. The nurses take samples of new syndromes and submit these to the Provincial Laboratory and Virus Laboratory as an epidemiological survey of illness in the community. The City Health Department services both public and parochial schools though the latter in Manitoba are not tax-supported. Dental services are concentrated by necessity to a comprehensive survey in Kindergarten and Grades I and II with follow-up in financially embarrassed families. In other grades, emergency service only is offered. The Child Guidance Clinic of Greater Winnipeg operates as a separate institution, staffed by the provincial Health Department and the School Boards of the Metropolitan Area.

Sanitation

There are public health inspectors attached to municipal health departments and health units who carry out routine inspections in their areas. In this field are the food and milk control programmes, water and sewage supervision, and investigation of complaints. The programme is of generalized sanitary inspection duties with the provincial section of environmental sanitation providing consultants from the bureaus of public health engineering, food and milk control, industrial hygiene, and the services of a central staff of nine public health inspectors.

Communicable Disease Control

All local health units receive notification of communicable diseases from local medical practitioners, school teachers, and parents. Through home visiting, quarantine, isolation, and education, the units endeavour to keep these diseases to a minimum. The medical directors, public health nurses and public health inspectors all participate in investigations of reported diseases. The medical director is available for consultation and diagnosis.

Standard immunization is offered on a continuous basis in all local health units, at child health clinics, at all schools and in local unit offices and sub-stations. When required, special immunization against typhoid, influenza, infectious hepatitis, and tuberculosis is made available. A programme of poliomyelitis immunization is offered by all local health units.

Tuberculosis Control

The Manitoba Sanatorium Board, a self-governing body with Government representation in membership, has administered anti-tuberculosis services in Manitoba for 50 years. Under the Act, as an agent of the Government, it is responsible for all aspects of Tuberculosis Control including case-finding, operation of sanatoria and rehabilitation and health education. It organizes the Christmas Seal campaigns, collects and administers funds. Clinical facilities are provided in the Manitoba Sanatorium, the Central Tuberculosis Clinic, and the Clearwater Lake Hospital. The latter is owned by the Federal Government and was set up for the treatment of tuberculous Indians and Eskimos. All new cases go to the Manitoba Sanatorium or the Clearwater Lake Hospital, or for short-term care to the central Tuberculosis Clinic in Winnipeg.

The Central Tuberculosis Registry records all cases and contacts. The Central Tuberculosis Clinic in Winnipeg functions principally as a centre for diagnosis, periodic re-examination of ex-patients, and supervision of out-patients, although 65 beds are available for short-term care. Here all X-ray films in the field and hospital admission X-rays of many general hospitals are processed. Consultation service to the Winnipeg General and other area hospitals is provided. Tuberculin testing and X-rays, through mobile vans, are carried out on vulnerable groups.

The Sanatorium Board organizes diagnostic travelling clinics and X-ray surveys. Examinations are confined to tuberculosis suspects, contacts and a review of ex-patients. There are also out-patient clinics in each sanatorium.

The public health nurses in the units supervise home care and assist in the rehabilitation of tuberculosis patients. The Nursing Section supervises the Central Tuberculosis Registry and is a liaison between sanatoria patients, the family doctor, the community, and health department personnel. Patients in the Manitoba Sanatorium as well as those in the Central Tuberculosis Clinic are visited for exchange of information and other purposes. Assistance is given in planning travelling clinics and the provision and planning of special tuberculin chest X-ray surveys to meet the need of each community.

The nurses in areas outside local health units assist tuberculosis clinics held in these areas and make home visits to patients and contacts living in the districts.

More recently the Sanatorium Board has accepted responsibility for the operation of extended treatment hospitals. These include the converted Sanatorium at Brandon, now called the Assiniboine Hospital, and some of the beds at Clearwater Sanatorium, The Pas. The Board will also operate the new Rehabilitation Hospital. Care in these facilities are included as benefits under the Manitoba Hospital Commission.

Venereal Disease Control

The control of venereal disease is an important part of the provincial health services programme. The Province operates a free Venereal Disease Clinic at the St. Boniface Hospital to provide diagnostic services and treatment in the Metropolitan Winnipeg area. Cases and contacts are located and investigated and follow-up of treatment is mainly through local practitioners. Drugs are supplied free of charge to physicians for every reported case. Laboratory services are available to doctors without charge.

Maternal and Child Health

There is a programme of prenatal education classes for expectant mothers. All health units also offer a service of advice, demonstration and supervision to expectant and new mothers. In all unit offices special lectures and classes of instruction in maternal nutrition, infant care, etc., are provided. Notifications of birth are received at unit offices, and members of the public health nursing staff make home visits to advise and assist the new mother. They also outline the services offered in baby clinics and the immunization facilities available at the local health unit.

All local units operate baby clinics to assist mothers with the care of infants and young children. They are located in the most accessible points and are held on a regular weekly or monthly basis. The purpose is to supervise the physical and emotional development of infants and pre-school children, to provide medical examinations, to detect defects and to recommend sources of corrective treatment. Immunization is available as well.

For the pre-school ages, similar services are available with emphasis on maintaining immunization. Special school-beginner clinics are held in all units with medical examinations provided to detect defects which may be corrected before the child starts school.

The Maternal and Child Health programme is under the Bureau of Maternal and Child Hygiene in the Section of Preventive Medical Services. It includes prenatal education institutes for nurses and classes for expectant mothers. Routine inspections of maternity homes and child-care institutions, as well as day nurseries, are carried out.

School Health Service

Each health unit endeavours to provide a programme of medical inspection, examination, and immunization for all school children in their unit area. The local unit staff are available to assist teachers with the health education programme, and give lectures, classroom talks, film showings, and sanitation demonstrations. The public health inspector conducts routine inspections of the schools.

Dental Health Service

In rural areas dental treatment clinics are operated by the Province in co-operation with a sponsoring local agency. Departmental mobile clinics visit areas which lack the services of practising dentists and a *per diem* operating cost of \$40.00 is guaranteed by sponsoring local committees. There is emphasis on education. In addition to the mobile system, stationary clinics for dental examination and treatment are part of the local health unit programme of Portage la Prairie and in districts suburban to Winnipeg. Children from indigent and low-income families receive priority in care provided. In Winnipeg, the City Health Department operates school dental clinics which examine all school children in elementary grades and provide emergency treatment on much the same priority pattern.

In 1959, a public health programme for the health units devoted to preventive measures for pre-school children was introduced. During 1961, plans for dividing the Province into four dental regions were completed. Regional offices have been gradually established. They work closely with the health units in the area.

Health Education

A special provincial Bureau carries out extensive work throughout the Province, including consultation with institutions, departments, staff, teachers, and official and voluntary agencies. All local health unit staff members are also involved in health education work.

Rheumatic Fever Programme

There is a special rheumatic fever programme. The Department of Health has an agreement with municipalities whereby the cost of penicillin and sulphathiazole used in rheumatic fever prevention is shared equally between the Department and the municipality of residence. No one is accepted unless the application comes from the attending physician and everyone in the Province who has suffered from the disease is eligible for prophylactic treatment.

Public Health Nursing

This provincial Section of Public Health Nursing provides recruitment, training, assignment of nursing staff, consultation to various institutions, special nursing services to tuberculosis control, crippled children and adults, venereal disease control, and generalized public health nursing. Most of the nurses are in the local health units and only a few in the central offices. Much of their work is described under other programme headings.

In certain districts, a generalized nursing programme is available, including bedside nursing, home visits, and health supervision in schools, comprising classroom inspection and talks, examinations, treatments, and interviews with teachers. In addition, immunization clinics are held in these districts and assistance is given to physicians with immunization against communicable disease of school and pre-school children.

Laboratory and X-ray Services

The provincial Section of Laboratory Services administers the Central Provincial Laboratory in Winnipeg and two branch laboratories serving other parts of the Province. Tests are performed free of charge. There is special provision at the Central Laboratory for the diagnosis and investigation of virus infections.

The Manitoba Health Services Act of 1945 provides for the establishment of prepaid laboratory and X-ray units in the Province. Six such units have been established. The staff are members of the provincial Health Department.

Further extensions are planned as personnel are available. Where these units exist, they are housed in hospitals and operate all in-patient lab and X-ray services for the hospital.

Northern Health Services

The provincial Department began a Northern Health Services Programme in 1959 in the unorganized territory north of the 53rd parallel. The Section is staffed by a medical director, two public health inspectors and four public health nurses and clerical staff. Activities include the organization, implementation and administration of a long-term integrated preventive and curative programme using all the resources of the Department and professional resources available, the transportation of urgent cases from remote areas to hospital, the provision for local health services at The Pas, the organization of camps and the utilization of industrial doctors as medical officers, and close co-operation with the Indian and Northern Health Service of the Department of National Health and Welfare.

Elsewhere in unorganized territory arrangements are made with the local physicians to give medical care as well as public health service to residents. An emergency transportation system is arranged in an effort to bring patients who are a provincial responsibility in to aid. It also looks after transportation to and from hospital of indigent patients who are a provincial responsibility.

Municipal Doctor Plans

There are nine medical care districts in which municipal physicians on salary are serving. In effect, these districts have local prepaid medical plans. Municipalities and municipal doctors are eligible for municipal grants if they are included in both a local health unit and a laboratory and X-ray unit.

Hospitals and the Hospital Insurance Programme

At the end of 1962, Manitoba had 108 hospitals of all types, with 10,818 beds available. Of these, 817 were for the care of the chronically ill, 74 for communicable diseases, and 5,586 for acute general use.¹ The hospitals are operated under lay, religious, municipal, provincial and federal auspices, with the largest number of beds available for general use.

¹ Rated bed capacity.

In July 1958, the comprehensive Manitoba Hospital Services Plan was begun. Initially, under the administration of a Commissioner with more limited functions, the programme has since been placed under the jurisdiction of the Manitoba Hospital Commission established in July 1962. It has responsibility for both the insurance side of the programme and for the licensing, inspection and control of standards of all hospitals, with the exception of mental and tuberculosis facilities, and for the planning and development of the hospital system in the Province. The Commission is directly responsible to the Minister of Health. Benefits under the insurance programme include complete in-patient care at the standard ward level. Out-patient services include emergency care within 24 hours of an accident and some 50 specified procedures. Electro-shock therapy, examination of tissue specimens removed in a hospital, and physiotherapy, occupational therapy, and speech therapy, when provided in four designated hospitals are also insured out-patient services. Provision is made for out-of-province benefits. Premiums are compulsory and are collected through payroll deductions for employer groups of three or more, and by semi-annual or annual payments payable at municipal offices, for all other persons. Premiums account for approximately 33 per cent of total revenues required by the Commission; the balance of the provincial share of the cost is provided from the general revenues of the Province. All recipients of public assistance and recipients of the Old Age Security Pension who have little or no income besides their pension, are insured without payment of premium. Although mental and tuberculosis care are not provided as insured benefits under the Manitoba Hospital Commission, such care is provided to residents of Manitoba without charge, as part of provincial health services.

Mental Health

The provincial Department of Health, through its Psychiatric Division, operates two mental hospitals for the treatment and custodial care of the mentally ill at Brandon and Selkirk. A Hospital-School for mental defectives is located in Portage la Prairie. In Winnipeg, the Psychiatric Institute provides diagnostic services and early short-term treatment. There are three out-patient departments in Winnipeg, Brandon, and Selkirk, as well as child guidance clinics operating in the Province. Full-time mental health clinics are located in areas surrounding the established institutions.

Rehabilitation

The Provincial Government has designated the Society for Crippled Children and Adults as the central rehabilitation agency. The Manitoba Sanatorium Board, the Canadian National Institute for the Blind, and Workmen's Compensation Board serve the tuberculosis patients, the blind, and injured workmen. There are also other agencies providing certain services for specific groups, such as the Canadian Arthritis and Rheumatism Society, the Greater Winnipeg Child Guidance Clinic, Speech and Hearing Clinic, the Manitoba Association for Retarded Children, the Canadian Paraplegic Association, and The Multiple Sclerosis Society.

The Provincial Co-ordinator of Rehabilitation Services generally supervises rehabilitation programmes, screens applicants, and promotes co-operation between the agencies and community resources. The Central Registry lists the

disabled persons of which it is estimated there are about 4,000 registered as active files. The following services are offered:

1. Medical, surgical or psychiatric procedures required in the treatment of disabling conditions.
2. Prosthetic appliances and training in their use.
3. Rehabilitation counselling.
4. Vocational services, testing, education, vocational training, and job placement.
5. Psycho-social adjustment services.

During 1962, the Rehabilitation Hospital with some 200 beds was opened in Winnipeg. All aspects of medical rehabilitation are provided. The hospital is the primary clinical resource in the Province for doctors and hospitals. It contains the new School of Medical Rehabilitation for the education and training of physio- and occupational therapists. The hospital is administered for the Province by the Manitoba Sanatorium Board.

The programme of the Society for Crippled Children and Adults includes an assessment clinic, provision of treatment services and prosthetic appliances, guidance, and follow-up services for all types of physical disability. The Provincial Government designated the Society to provide comprehensive services to physically disabled children and adults. Rehabilitation assessment and follow-up services to chronically disabled people with a limited total potential because of the combination of disability, age, social disfunction, and economic incapacity, are provided by the Alternative Care and Elderly Persons Housing sections of the provincial Welfare Department. This work is tied in with other rehabilitation services through the Provincial Co-ordinator. Physiotherapy, occupational therapy, and speech therapy are insured out-patient benefits under the Hospital Insurance Plan when these services are provided by the Rehabilitation Hospital and the Municipal Hospitals of Winnipeg, by the Assiniboine Hospital in Brandon, and by the Clearwater Lake Hospital at The Pas.

The Society for Crippled Children and Adults employs a staff of 14 social workers and psychologists to provide case work and vocational counselling and to co-ordinate the various services. Medical assessment is carried out by private physicians at regular out-patient clinics or at rehabilitation assessment clinics attended by specialists as needed. The Chief Medical Consultant of the Society advises on policy. Maintenance of residence outside Winnipeg is provided during the period of assessment and treatment.

The industrial workshop in Winnipeg operated by the Society provides vocational evaluation, work conditioning, and sheltered employment. Following assessment and approval by the training and selection committee, disabled persons who require training in order to enter competitive employment are sent to the Manitoba Technical Institute or to private schools. In addition to utilizing the services of the National Employment Service, the Society for Crippled Children and Adults employs two special placement officers to aid the more severely handicapped in finding employment.

The children's programme of the Society for Crippled Children and Adults serves most handicapped children except those with visual defects, rheumatic heart disease, and mental defects, who are cared for by other agencies. Under the Society's Chief Medical Consultant medical evaluation is arranged with private specialists in Winnipeg and diagnostic clinics held in rural areas and special cerebral palsy clinics at the Children's Hospital. Most children receive medical

are in hospital as staff patients. Treatment is also purchased from specialists. Orthopaedic aids and wheel-chairs are supplied by the Society. Two social workers handle referrals, arrange clinics, and provide social assessment in case of follow-up.

Initial screening clinics in rural areas are arranged, attended by a team of psychologists, speech and hearing therapists, and social workers. These are followed by the regular diagnostic clinics attended by medical specialists, social workers, and a physiotherapist. Consultant services are provided by the family doctor. Arrangements are made to send to Winnipeg hospitals any children in need of treatment.

The Winnipeg Health Department screens all school children and identifies the handicapped. It maintains records of them and refers them for treatment with appropriate agencies such as the Society for Crippled Children and Adults and follows up each child. The provincial health units also screen school children and maintain registries of handicapped children and assist the Society in organizing diagnostic clinics and arranging treatment in Winnipeg. The Education Department pays the cost of educating blind and deaf children in residential schools outside Manitoba and employs teachers in several hospitals. It operates a day school for deaf and hard of hearing children in Winnipeg. The Child Guidance Clinic of Greater Winnipeg provides psychological testing and vocational guidance. Its speech and hearing department give a school consultant service as well as therapy.

Chronic Disease Services

During 1960 an alternative care assessment and follow-up programme, as alternative to active treatment hospital care, was developed by the Province. Its purpose is to serve people who may not become economically independent but can benefit from proper assessment of potential abilities and rehabilitation services to maintain the maximum functional level and placement in a suitable environment. Joint health and welfare assessment panels are organized in several health unit areas involving senior personnel, i.e., the Medical Director of the unit and the Welfare Supervisor, to review and plan for the care of chronically ill persons. A similar panel covering the Greater Winnipeg area and operated by the Department of Public Welfare has been in operation for several years. In recognition of the specialized needs of patients with chronic and long-term illnesses, special emphasis has been placed on the development of extended treatment facilities in the Province. At the end of 1962, total capacity in extended treatment beds had more than doubled from 1958. The additional beds were obtained by the conversion of existing tuberculosis facilities which were no longer needed due to the rapid reduction in requirements for hospital facilities for tuberculosis patients. In the planning of extended treatment facilities the need has been recognized for the provision of extended treatment units in the smaller centres of the Province, affiliated with existing acute general hospitals. Under this programme, a first unit of 35 beds has been completed at Dauphin, Manitoba, and others are in the planning stages. The extended treatment facilities in the Winnipeg area are also to be augmented in the immediate future by the addition of approximately 200 beds.

Cancer Control

The Manitoba Cancer Treatment and Research Foundation is subsidized by the Province and administers all cancer activities. A free biopsy service is available and diagnostic services are provided free to medically indigent rural

residents. In the Greater Winnipeg area services are available through the out-patients' department of the Winnipeg General Hospital and St. Boniface Hospital, with which the Foundation is associated. A deep X-ray therapy and cobalt bomb treatment centre is maintained by the Foundation in association with each hospital. Treatment is free to all residents. A radium treatment is also available in each hospital.

Home Care

The Winnipeg municipal hospitals began a home care plan in 1956 to care for a number of poliomyelitis respirator patients. It has since been broadened to include patients with chronic illness and integrated with the Home Care Programme of the Winnipeg General Hospital. Services include regular medical follow-up and social service arrangements for special needs. Costs of attending home nursing or housekeeper service and special equipment are met by the provincial Health Department and the Society for Crippled Children and Adults.

Care of the Aged

Joint health and welfare panels for the aged are organized in several health units involving the medical health officer and welfare supervisor to review and plan for the care of chronically ill persons. Institutions and boarding homes for the aged are supervised by the Departments of Health and of Public Welfare. Provincial construction grants are paid to municipalities and other organizations building such facilities. Costs of maintenance of the aged in homes for the aged are covered on the basis of need by the Province.

Welfare Programmes

Indigent medical care is provided under an agreement with the Manitoba Medical Association and the Manitoba Medical Services Plan by the provincial Welfare Department for cases of need among the aged and infirm including those in nursing homes or institutions, the blind, the physically or mentally disabled mothers with custody of dependent children, and neglected children. Services include medical, surgical, optical, and dental care, essential drugs, remedial care and treatment including physiotherapy, emergency transportation, and chiropractic. Persons in receipt of provincial assistance are covered under the Hospital Services Insurance Programme without payment of premiums. Persons exempt from the payment of premiums in this way include recipients of Mother's Allowance, Child Wards of the Province or children under the care of the Director of Public Welfare or Children's Aid Society, and recipients of the Blind Persons', Disabled Persons', and Old Age Assistance Allowances. In addition, a high percentage of old age security pensioners have been exempted on the basis of a means test. Other residents of most municipalities are assured of coverage by arrangements under which a municipality guarantees premium payments for all legal residents and in return receives assurance that all legal residents will be continuously covered as insured persons under the hospital services programme. This provides uninterrupted coverage to persons who are from time to time unable to pay their premiums. One hundred and eighty out of a total of 150 municipalities participated in this programme at the end of 1962 and more than 95 per cent of the population of Manitoba thus came under the guaranteed insured status. Unless they provide for this contingency by guaranteeing premiums in this way, municipalities are liable under provincial legislation for unpaid hospital accounts incurred by legal residents.

Except in the municipal doctor areas other indigents receive medical treatment as provided at local discretion on a fee-for-service arrangement between the doctor and municipality concerned. The municipality is reimbursed by the Province either at a rate of 40 per cent or at 80 per cent of any amount in excess of one mill under equalized assessment. The Province is responsible for indigents without established municipal residence or in unorganized territory. In the case of the municipal doctor districts, the municipality pays the premium or property tax for indigents.

Provincial Comments

One correspondent writes:

"I heartily endorse your concept of larger health regions, involving both hospitals and health departments, and probably welfare and housing authorities.

"Last summer our Nursing Division carried out a survey of all lapsed cases from child health centres in one district. It was their finding that lapsed cases was the true terminology. The Manitoba Medical Service is probably the most comprehensive prepaid scheme in Canada. I have not seen their figures, but I would venture that they would also show negligible medical attendance after one year except in acute illness. I feel there really is a gap in health supervision between infancy and kindergarten. This is the period where disabilities of hearing, sight, mentality, heart and even locomotion are probably overlooked.

"I agree with attachment of public health nurses to general practitioner groups. I think this is difficult in the city, but feasible in rural areas and even more desirable in rural areas where only one physician practices. I think there would be initial resistance by many practitioners and possibly health officers.

"I do not think consultants in clinical fields should be too closely linked to health departments, preferably they should be on the full-time staff of a hospital region and be selected and hired by the attending staff of that region.

"I agree on a combined nursing service. Unfortunately our present system with its controls makes expansion of health department staff more difficult than voluntary agencies, even though the latter are largely dependent on government grants. Hence voluntary services expand into fields more logically covered by official agencies.

"I can see the logical necessity of a regional system, with co-ordination of facilities and economical sharing of both staff and facilities. I think local pride is a major stumbling block here. The public health and hospital regions should be identical in area, and linked in administration.

"I feel very strongly on the subject of social welfare services. One of the latest bits of social work jargon is the 'family centred service'. I feel that this has always been a feature of the visiting public health nurse. Whether she likes it or not she is involved in social and welfare work. This is so in the City, but is even more so in rural areas where the visiting nurse is the only representative of health or welfare services. I feel we should accept this role of the public health nurse as the family centred field worker, and offer additional training in recognition of when and where to refer. The University of Glasgow is training combined public health nurse—social workers.

"I am in agreement with combined health and welfare departments and regional offices. I agree on the regional board system with the maximum local autonomy of that board within defined limits and patterns. I agree that more training in administration is required by most health and welfare people including this writer."

A second correspondent writes:

"We have reached very much the same kind of regional concept that appears in your recommendations. Acceptance of such a goal will depend primarily on provincial Public Health Departments and Hospital Commissions."

A third person writes:

"I feel quite strongly about the co-ordination and integration of the health service through regionalization and am confident that many of our existing problems will now and cannot be resolved until such a policy is implemented."

SASKATCHEWAN

Public Health

Organization

Public health services are provided through a system of health regions which cover the entire Province except for the Cities of Regina and Saskatoon. The latter have their own municipal health departments with full-time medical officers of health and other staff which operate under boards of health. Each of the 12 health regions in the settled areas serves a population of approximately 50,000—80,000 people and covers an area of between 6,000—18,000 square miles. They are administered jointly by regional health boards and the provincial Public Health Department. Each health region is divided into public health districts and the health regions include a city or major town as the regional health centre.

The northern half of the Province, known as the Northern Administrative District, is the only part of the Province not organized as a health region but as a special health district which serves the population of less than 20,000 people over an area of about 119,000 square miles. The headquarters for this health district is at Prince Albert. The full-time staff there include a medical health officer, a public health nurse—midwife supervisor, and a senior sanitary officer, who makes periodic visits throughout the area. The Public Health Department also maintains four outpost hospitals in the district which are staffed by public health nurses—midwives. These fall under the jurisdiction of the medical health officer.

All regional public health personnel are full-time provincial civil servants. A health region has on the average some 22 staff members including the medical health officer,¹ public health nurses, sanitary officers, health educator, nutritionist, educational psychologist, dental hygienist, and clerical staff.

Regional boards of health function as the statutory bodies representing each constituent rural or urban municipality in the region. They have authority to introduce, finance, and administer, subject to the Minister's approval, any type of health programme. Thus, they may own and operate hospitals, though none of them. Some are becoming interested in home care programmes. A tax-support regional medical care plan was established in 1946 in the Swift Current Health Region. The programme continues to operate in somewhat the same form as before with a moderate degree of autonomy under the terms of The Saskatchewan Medical Care Insurance Act of 1962 and its amendments.

All urban and rural municipalities in a region appoint representatives to a district health council, which, in turn elects, on a population basis, one or more of its members to the regional board of health. The district health councils were

¹All regional medical health officers hold the Diploma of Public Health or its equivalent. Several also are certificated specialists in Public Health of the Royal College of Physicians and Surgeons of Canada.

originally conceived as one place where community understanding of public health services could be initiated. They have had limited success in this respect. They meet to discuss programmes and issues, to hear reports from the regional medical health officers, and to fill vacancies on the regional board. The regional health board meets periodically to review the health progress in the region and to consult with and advise the regional medical health officer. It is responsible also for reviewing the budget and making recommendations to the Minister of Public Health.

Regional public health services are financed jointly by the Province and the municipalities. Provincial tax revenues meet about 75 per cent of operating costs on the average. In no case is a municipality obliged to pay more than 50 cents *per capita* per year. National Health Grants are also used for financing certain services where available.

The provincial Regional Health Services Branch supervises the work of the regional medical health officers and co-ordinates policies and services among the regions. The Department's technical divisions provide direct services and consultation to the regions as needed.

Sanitation

Each health region employs qualified sanitary officers to carry out routine inspection duties for water supplies, sewage disposal, and milk production, processing, and distribution. Supervision of food handling, food outlets and restaurants, and all types of food processing plants is provided. The sanitary officers also carry on active health education work, for example, food handler schools and camp hygiene.

The provincial Division of Sanitation (Sanitary Engineering) actively supports the health region work through consulting and technical services to the municipalities on water supplies and sewage disposal systems. It also carries out routine inspection of water and sewage systems.

Four milk sanitarians employed by the Department supervise milk pasteurization plants and the quality of pasteurized milk throughout the entire Province.

Communicable Disease Control

The local regions and municipal health departments operate under regulations governing the notification, prevention, control, and treatment of communicable diseases. Mass immunization is carried out in all health regions and the major cities. Protection against smallpox, diphtheria, pertussis, tetanus, and poliomyelitis is maintained. One unusual characteristic is that the bulk of the immunization procedures are carried out by public health nurses. Special emphasis is placed on immunization against poliomyelitis for both adults and children. Salk vaccine had been received by 97.8 per cent of children under 16 years of age and 69.1 per cent of adults between 17 and 40 years of age by December 30, 1960. During 1962, about 85 per cent of the population received one dose of tri-valent, oral, Sabin vaccine. All children received a second dose of Sabin vaccine in February and March of 1963.

In all health regions, programmes for the control of streptococcal disease which can lead to rheumatic fever are conducted. These include the free distribution of penicillin for streptococcal infection, including scarlet fever, and continuous prophylaxis in proven cases of rheumatic fever. Medical Advisory

Committees function in each region to assess cases submitted by the attending physicians.

Tuberculosis Control

Since 1911 the Saskatchewan Anti-Tuberculosis League has been responsible for the programme of tuberculosis control and treatment under the Tuberculosis Sanatoria and Hospitals Act. Two sanatoria are in operation, a Saskatoon and at Fort Qu'Appelle. Provincial assistance is provided by a *per diem* grant of \$4.00 from the Province for all patients. The balance of the cost is raised by tax levies on the municipalities. In addition, the Dominion Government purchases services for Indians and Eskimos, and National Health Grants are made available for preventive programmes. The tax funds from the municipalities amount to about one-half of the total cost.

Case-finding programmes are conducted on a province-wide basis using mass tuberculin testing and follow-up chest X-ray procedures, and special surveys of particular exposure and high risk groups, such as those in the northern districts. Hospital admission miniature chest X-rays are carried out. Regular chest clinics are held at the sanatoria and at certain community hospitals. The case-finding activities are supported mainly from voluntary donations, such as the Christmas Seal campaign.

Preventive services among the Indians are carried out by the Indian and Northern Health Services of the Department of National Health and Welfare in co-operation with the League. The former conduct the surveys and the League interpret films and provide clinical referral services.

Venereal Disease Control

This programme is directed by the provincial Division of Venereal Diseases Control. Government clinics for the free treatment of cases and contacts are provided in Regina, Saskatoon, Moose Jaw, and Prince Albert. Practising physicians are reimbursed for treatment. Contact examination, case-finding, and contact follow-up are carried out by the staff of the Health Regions and city Health Departments. Free treatment drugs are provided. Hospitalization is paid for where considered necessary. Consultative services are available to physicians. An education programme is carried on by the Division of Health Education.

Maternal and Child Health

The provincial Division of Child and Maternal Health has two full-time consultants, an obstetrician and a paediatrician, both trained in public health, whose services are available for consultative work and who set standards, develop programmes, and co-ordinate activities among the regions.

In the health regions, the public health nurses carry out prenatal classes and visiting and post-natal visiting in co-operation with local doctors and hospital personnel. Routine phenyl-ketonuria testing is done on newborn infants. Child health services are provided through conferences or clinics. The regional nutritionist gives advice on maternal and infant diets.

School Health Service

In the health regions, pre-school clinics are held. The public health nurses carry out an active school programme, including classroom visits and conferences with teachers and school officials. Under the prevention of blindness programme children with defective vision are referred for ophthalmological examination and

reatment, if indicated. If they require glasses, these are provided without charge when the parents are unable to pay. The regional nutritionist carries on a school nutrition education programme. The educational psychologist works closely with teachers in promoting sound mental health practices in the classroom and in handling "problem" children. The sanitary officers check on lighting, water supply, waste disposal and safety of playgrounds in the schools. The provincial Health Education Division works closely with the schools.

Public Health Nursing

Most local regional services have been described. The provincial Division provides consultation to and co-ordination among the regions. This Division also arranges for and supervises field experience in public health nursing for students from the university and hospitals. Further, the provincial Director of Nursing is assisted by four nursing consultants who assist and advise on Maternal and Child Health, Rehabilitation Nursing, and other public health nursing programmes.

Laboratory Services

Public health tests and other examinations are provided free through the Public Health Laboratory in Regina. In addition it provides a mail order clinical testing service for doctors in small hospitals and rural areas. The Provincial Laboratory supplements whatever examinations are available on the local level. It serves as a reference and standards laboratory for clinic and hospital laboratories in the Province. The major divisions of the laboratory are bacteriology, chemistry, haematology, immunology, virus, and milk and water.

Dental Health Service

The provincial Division carries out a consultative and promotional programme. Because of the inability to recruit a sufficient number of dental officers, only two regional dental care programmes for children are being carried out. These are in the Swift Current and Assiniboia Regions. Programmes in Regina and Saskatoon, which were preventive primarily but did provide some curative services, have been modified because of a shortage of personnel.

Fluoridation of community water supplies is carried out in a total of 51 urban communities. Health regions issue fluoride tablets to expectant mothers and pre-school children. Five health regions supported dental hygienists who conducted programmes of prevention and dental health education. These programmes have had to be discontinued because of a shortage of hygienists. Under the Social Aid Act basic dental health care is provided for people in a variety of public assistance categories.

Health Education

The provincial Division has a most active programme and works closely with the health regions, schools, and other community groups in activities, such as anti-smoking work, mental health, and dental health.

Hospitals and the Hospital Insurance Programme

The Canadian Hospital Directory 1963 lists 169 hospitals with 12,731 beds in Saskatchewan. Of these, 615 beds are for chronic diseases, 86 for contagious diseases, 6,744 for general use, 4,654 for mental illness, 47 for orthopaedic, and 413 for tuberculosis. One hundred and twenty hospitals are operated by municipalities and the remainder by lay boards, religious orders, and the provincial and federal authorities.

The Saskatchewan Hospital Services Plan, started in 1947, was the first of its kind in North America. It is now part of the Dominion-Provincial Programme. On the payment of a personal or family tax, the plan provides standard in-patient ward care for persons who have resided in the Province for three months. Extra services such as drugs, laboratory work, X-ray diagnosis, and therapy, operating room, delivery room, and anaesthetics are provided. The 1964 hospital tax is \$20.00 for an adult or a maximum of \$40.00 per family. There is no tax for dependents to the age of 18 years. Comprehensive out-patient services are also provided under the Plan.

Medical Care

Under the Saskatchewan Medical Care Act of 1962 and regulations, payment for the services of doctors is provided directly by the Medical Care Commission or through designated medically sponsored agencies and a joint insurance company agency for all residents known as "approved health agencies". The Plan is compulsory and is partially financed through a premium. The annual premium is \$6.00 for a single person and \$12.00 for a family. This is collected as a joint tax of \$26.00 for a single person and \$52.00 for a family. No details are being given here. The Plan is simply mentioned in order to present a complete picture of services.

Mental Health

Under the Saskatchewan Public Health Department, two mental hospitals are operated at Weyburn and North Battleford. A Psychiatric Centre with provision for 148 beds and comprehensive out-patient and day-patient services is being opened in stages to serve the area in and around Yorkton. There are intensive treatment psychiatric wards in general hospitals in Regina and Moose Jaw and full-time mental health clinics in these two centres and in Saskatoon, Swift Current, and Prince Albert. Part-time mental health clinics are provided to 19 localities. A Psychiatric Research Unit rents space in the University Hospital at Saskatoon. The University Hospital operates a psychiatric ward and an out-patient service with financial support from the Department.

The modern training school in Moose Jaw provides care to 1,109 retarded children and adults. Accommodation for 300 retarded adults is provided in Prince Albert.

Rehabilitation

The responsibilities for rehabilitation are shared by several departments of government and voluntary agencies. They operate within a co-ordinated structure which minimizes gaps and overlap. At the governmental level an Interdepartmental Co-ordinating Committee on Rehabilitation meets regularly and assigns responsibility to specific departments. On the provincial level a Co-ordinating Council on Rehabilitation representing some 40 agencies serves to acquaint voluntary, professional, and governmental agencies of programme developments. A Provincial Co-ordinator of Rehabilitation acts as secretary of the Interdepartmental Committee, as well as serving as Executive Director of the Co-ordinating Council.

Comprehensive vocational rehabilitation services are provided by the Department of Social Welfare. The Department of Public Health operates two large physical restoration centres at Regina and Saskatoon and provides technical personnel on a loan basis to other programmes. It also operates an appliance and

prosthetic centre. The Department of Education assists local communities to set up special classrooms for physically and mentally handicapped children and makes special grants to these children.

The Saskatchewan Council for Crippled Children and Adults provides mobile clinics, job assessment and work conditioning centres, appliance services, and a transportation service for the handicapped. These programmes are assisted by the Department of Public Health. The Canadian Arthritis and Rheumatism Society operates a limited mobile physiotherapy service. Other active voluntary organizations are the Canadian National Institute for the Blind, Canadian Red Cross, Handicapped Civilians Association, and professional associations.

In addition to benefits provided under the Medical Care Act, people with certain diseases or disabilities, such as alcoholism, arthritis and rheumatism, rheumatic fever, hearing and vision defects, cerebral palsy, polio, paraplegia, and orthopaedic conditions may receive medical care through a number of public and voluntary programmes, mainly those conducted by the provincial Health Department and the Saskatchewan Council.

As well as the regular medical and diagnostic facilities available at the out-patient departments of the Physical Restoration Centres, there are clinics for cases of paraplegia, cleft palate, glaucoma, low vision, and neurological conditions, held at the University Hospital in Saskatoon. Weekly treatment clinics for polio, cerebral palsy and orthopaedic disabilities are held at the Physical Restoration Centres; also a cleft palate clinic is held monthly at the Saskatoon Centre.

Home Care

The Department of Rehabilitation Medicine of the University Hospital initiated an organized home care programme in 1959 for patients suffering from neurological disorders such as hemiplegia, paraplegia, post-poliomyelitis and cases of depression. The project provides medical care, home nursing by the Victorian Order of Nurses, orderly service, social service, and housekeeping to about 50 patients annually with a daily case load of about 10.

There are also two other home care projects. A home care programme operated by a community board is in operation in Moose Jaw with a case load of about 30. A home care programme for psychiatric patients who would ordinarily be admitted to hospital is in operation on a limited basis in Saskatoon under the guidance of the University Department of Psychiatry. Plans are under way for regional home care programmes integrated with the regional public health nursing services, which would undertake comprehensive nursing.

Care of the Aged

The Housing and Nursing Home Branch of the Social Welfare and Rehabilitation Department of the Provincial Government provides skilled nursing-home care in several centres in the Province. Grants for construction are available to municipalities, religious bodies, and other groups, for building homes for the aged and housing projects. Maintenance costs for the needy or homes for the aged are shared between the Province and municipalities.

The Health Department has sponsored an "Aged and Long Term Illness Survey Project" to conduct research on health and social needs of this group as well as organizing a public education programme. A 16-member committee

worked two and one-half years to plan for the development of facilities and programmes for the aged and long-term ill. Regional conferences have been held at several regional centres. There have been studies, surveys of employers, and surveys of the over 65 age group in nursing homes, homes for the aged, and geriatric centres. The report of this committee was tabled in July 1963 and contains a large number of recommendations.

Welfare Programmes

Many have been mentioned already. Under the Saskatchewan Hospital Services Plan and Medical Care Insurance Plan, self-supporting residents able to pay their taxes are required to insure themselves, and public assistance recipients are covered by the Province. The municipality is responsible for paying the hospital tax and medical care premium for municipal residents who are unable to pay. The Department of Social Welfare and Rehabilitation reimburses the municipalities for about 93 per cent of the cost of assistance given those in need. Each year the municipalities are assessed on a per capita basis for about 7 per cent of the cost of social aid; the Province then reimburses them for all actual expenditures.

Child welfare, adoption, and unmarried mothers' services are provided by the Province. This includes costs of maintenance in institutional facilities.

Provincial Comments

Instead of much personal comment, our correspondents enclosed documentation outlining their views. In general, these materials support the concept of a regional development of health services including public health services, general and basic specialist medical care, hospital care, social welfare services, mental health services, geriatric services, organized home care services, ambulance services, nursing homes, rehabilitation services, and certain other services. A regional demonstration project is suggested in order to solve practical problems in implementing the proposals. The materials included:

1. *Proposals for the Organization of Health Services for Saskatchewan*, a submission by the Regional Boards of Health of the Health Regions of Saskatchewan to the Advisory Planning Committee on Medical Care (January 12, 1961), (mimeographed).
2. Continuing Committee on Regional Boards, *Supplementary Report on Proposed Integrated Health and Welfare Regions*, a submission to the Advisory Planning Committee on Medical Care (July 7, 1961), (mimeographed).
3. Government of the Province of Saskatchewan, *Brief to the Royal Commission on Health Services* (January 1962), (mimeographed) and supplement of August 27, 1962 (mimeographed).

ALBERTA

Public Health

Organization

Responsibility for health services rested with each local municipality until 1929 when legislative provision was made for the organization health units, each serving a group of municipalities. There are now 24 health units, each

serving an average population of 28,000 people and covering the settled areas, excluding Edmonton and Calgary. The administration is provided by a local board composed entirely of members appointed by the participating municipal councils. Each unit area is divided into wards and from each of these there is a representative from one of the included municipal councils. Thus, board size is kept relatively small. Staff appointments are made by the health unit boards.¹ Day-to-day administration is by the medical officer of health. The average staff consists of a medical officer of health, four to five public health nurses, one sanitary inspector, one or two stenographers—technicians, and a part-time secretary-treasurer.

The cost of operation is divided between the Province and the local municipalities.² The method of provincial payment is a general per capita grant according to the size of the unit.³ The municipalities which constitute the unit must provide an amount equal to at least two-thirds of the provincial grant.

Full-time city health departments providing a full range of public health services, including school health services, serve Edmonton and Calgary. They receive annual provincial grants of 50 cents per resident for general public health purposes and 10 cents per resident for dental health services.

Except in a few districts served by municipal nurses,⁴ public health services in sparsely settled, unorganized areas, which are not included in a health unit, are a direct responsibility of the provincial Department of Public Health.

The provincial Division of Local Health Services provides advisory and consultative services to the local boards and staff on administrative and technical matters. It also handles the payment of grants to city health departments and health units. Basic services are decentralized but the provincial Department of Public Health and Provincial Board of Health supervise and subsidize local services and operate directly certain special services and services in unorganized areas outside health units.

Sanitation

The major responsibility for sanitary inspection and education rests with the local public health department or health unit, whose sanitary inspectors are responsible for supervising all aspects of environmental sanitation including food supplies, dairies, slaughter houses, bakeshops, restaurants, tourist camps, logging camps, water supplies, and sewage disposal systems. The provincial Division of Sanitary Engineering offers a consulting service to city health departments and health units, but assumes direct responsibility for the special problems of stream pollution and air pollution which are related to the petroleum and petro-chemical industries. Law enforcement in relation to environmental sanitation is invariably left to local boards of health.

Communicable Disease Control

The local health departments and units carry out the regulations about notifiable diseases, implement isolation and quarantine measures, distribute free

¹There is a provincially set minimum salary for each category of health unit employee. This scale also serves as the basis for contributions to the Public Service Pension Fund.

²Minimum expenditure is about \$1.60 per capita per year.

³A grant for dental services amounting to one-fifth of the general grant is also given.

⁴Municipalities may appoint nurses. A few in unorganized areas outside units have done so.

biologicals, and carry out immunization programmes. Emphasis is placed on immunization against poliomyelitis in persons up to the age of 40 years. Nearly all immunization is done by public health nurses. This assures continuity of service and uniformity in recording.

Under the Rheumatic Fever Prophylaxis Programme, children under 16 years of age whose physician reports a history of rheumatic fever are eligible for prophylactic benefits including distribution of penicillin tablets.

Tuberculosis Control

Tuberculosis services in Alberta are the joint responsibility of the provincial Division of Tuberculosis Control, the Alberta Tuberculosis Association, and the local health units. The Division directs the over-all preventive programme, operates diagnostic clinics, and administers the two sanatoria at Edmonton and Calgary. The Alberta Tuberculosis Association supplies personnel and equipment for general survey work and other preventive and welfare measures with the co-operation of the local health units. The costs of mobile units are shared between the Province and the Association. Local health units and city departments are responsible for screening positive reactors among the school population as well as tracing contacts.

Venereal Disease Control

The Division of Social Hygiene of the provincial Health Department conducts the venereal disease programme. Compilation of data, advisory and consultation services to physicians, and the supplying of drugs free of charge to doctors are part of the service. Clinics are located in Edmonton, Calgary, and Lethbridge, and in two jails. A mobile clinic serves the remote areas.

Maternal and Child Health

These programmes, carried out largely by the public health nurses, are decentralized through local health units and municipal nursing districts as part of the general public health programme. The services include prenatal classes, post-natal visits, infant and child health conferences, clinics, and home visits, and pre-school consultations and visits. Immunization is given to children against diphtheria, tetanus, pertussis (only up to 5 years of age), poliomyelitis and smallpox. Prenatal supervision is provided by family doctors, out-patient clinics in larger hospitals, and by the Victorian Order of Nurses in Edmonton, Calgary, Lethbridge, and Medicine Hat.

A provincial Registry of Crippled Children is maintained.

Health Education

The Health Education Service of the Division of Local Health Services provides a consultative and advisory service in planning and implementing public health programmes to meet specific health needs. The service encompasses two broad areas, first, working with people on an individual and group basis, and second, the selected use of the various media of communication.

Nutrition

The Nutrition Services Section provides a school service including animal feeding demonstrations, food survey records, and materials for teachers. Education in the school lunch programmes is carried out on a long-term basis.

Dental Health Service

A dental service may be provided by city health departments and health units under full-time or part-time dental directors. These services are primarily of a preventive nature,¹ but emergency treatment also may be included. Emphasis is placed on the childhood population. The provincial Division gives consultation and financial aid to these programmes. The annual dental grant available to health units is equivalent to one-fifth of the general health services grant. The grant must be matched locally by two-thirds of its amount. Cities with a population of over 100,000 are eligible for payment of ten cents per capita per year. The dental programme has been limited in extent of service offered and in the number of areas with service by shortages in personnel.

Laboratory Services

Two public health laboratories are operated by the University of Alberta for the Department of Public Health. The central laboratory is in Edmonton and a branch is in Calgary.

Hospitals and the Hospital Insurance Programme

The Hospitals Division of the Alberta Department of Public Health is primarily responsible for the Hospital Insurance Programme. The costs are covered about 40 per cent from federal sources. The provincial share comes from general revenue. A monthly payment is made to each hospital based on the number of beds. The payment covers the approved cost of the hospital less income from other sources. This is the cost of maintaining a hospital ready to receive patients while the co-insurance paid by the patient on a *per diem* basis approximately covers the extra cost of his stay. The co-insurance rate is from \$1.50 to \$2.00 per patient-day. Public welfare recipients do not pay co-insurance.

According to the 1962 Canadian Hospital Directory, there were a total of 135 hospitals with 16,385 beds in Alberta, 1,824 were for chronically ill, 36 for contagious, 32 for convalescent, 8,577 for general use and 4,834 for mental patients. There were 84 beds for orthopaedic patients and 998 tuberculosis beds.

Mental Health

Under the Mental Health Division of the Department of Public Health there are three main sub-divisions; Institutions, Guidance Clinics, and the Eugenics Programme. There are hospitals located at Ponoka, Claresholm, Raymond, Edmonton, and Camrose. There is a training school for mental defectives at Red Deer. There is a special section for the care of emotionally disturbed children. Psychiatric wards are operated under the Hospital Insurance Plan at hospitals in Edmonton and Calgary and extensive out-patient services also provided.

Guidance clinics are held regularly at Edmonton, Calgary, Lethbridge, and Red Deer. Local clinics under health unit arrangements are visited periodically by guidance clinic teams.

The Sexual Sterilization Act enacted in 1928 was the first of its kind in the Commonwealth. Administration is by the Eugenics Board appointed by the Lieutenant-Governor in Council.

¹For example, cleaning, scaling, and application of topical fluorides to children.

Rehabilitation

The Department of Public Welfare has established a vocational rehabilitation programme in co-operation with the Department of Education, National Employment Service, and other agencies. The Department of Public Health operates restorative services for cerebral palsy, young arthritics, poliomyelitis and other chronic diseases. The voluntary organizations concerned with specific disability groups also provide services. The services available are hospital and medical care, physiotherapy, both in- and out-patient service, dental, optical, nursing, podiatric and chiropractic, under approval of the Medical Services Division. Prosthetic services to post-polio and cerebral palsy patients are provided by the Public Health Department. The Department of Public Welfare provides prostheses, including hearing aids, as part of the medical treatment service in its rehabilitation programme for disabled people. Vocational rehabilitation services are available to those aged 16 or over under the Public Welfare Act. Employment services for the handicapped are available through the National Employment Service.

In Edmonton and Calgary there are public clinics for alcoholism, rheumatoid arthritis, and cerebral palsy. The University Hospital has orthopaedic, orthoptic, and glaucoma clinics. The Children's Hospital has orthopaedic and orthoptic clinics.

Out-patient physiotherapy at a number of hospitals and occupational therapy at several hospitals are also provided.

The provincial Co-ordinator of Rehabilitation works closely with various voluntary groups serving the disabled, and chairs the Inter-departmental Rehabilitation Committee which reviews, advises on policies, and co-ordinates government services. The Alberta Council for Crippled Children and Adults is a voluntary central provincial body that co-ordinates the services of approximately 50 organizations, including local rehabilitation societies, The Cerebral Palsy Association, service clubs, and other groups interested in rehabilitation. The Council may pay for services on behalf of children referred by the affiliated groups and clubs. Services the Council may provide include transportation to treatment centres, diagnosis, medical care, prostheses and appliances, and other special needs, where financial need exists and where these services would not be available otherwise. The Council operates a summer camp for disabled children and adults. Principal treatment facilities are the Alberta Children's Hospital and the University of Alberta Hospital.

Some of the voluntary health agencies concerned with rehabilitation of specific disability groups include the Alberta divisions of the Canadian Tuberculosis Association, Canadian National Institute for the Blind, the Canadian Arthritis and Rheumatism Society, the Western Canada Epilepsy League, and The Cerebral Palsy Association. Some provide services to the disabled regardless of disability. Government-supported rehabilitation workshops for vocational training in limited programmes and for sheltered employment are operated by voluntary societies in Edmonton, Calgary, Lethbridge, and Medicine Hat. The Canadian Foundation for Poliomyelitis and Rehabilitation, Alberta Chapter co-operates with other rehabilitation agencies wherever there are unmet needs. An out-patient rehabilitation centre for injured workmen is maintained in Edmonton by the Compensation Board. The University of Alberta Hospital, Edmonton, also has extensive facilities. The Alberta Council for Crippled Children and Adults provides services not available under government auspices to handicapped children.

The Education Department has the responsibility for special education, operates the Alberta School for the Deaf, and supports local school boards and voluntary groups in maintaining special classes for exceptional children.

The Alberta Hospital Insurance Plan covers chronic disease. It has approved ten nursing homes and will build 32 auxiliary hospitals. These will serve geriatric and long-stay patients who require mainly nursing and physiotherapy.

Home Care

Home care nursing services are provided by the Victorian Order of Nurses in Edmonton, Calgary, Lethbridge, and Medicine Hat.

Care of the Aged

A number of homes for the aged have been built by the Provincial Government during the last three years. These are administered by local boards under the general supervision of the Alberta Department of Public Welfare.

Welfare Programmes

The Province reimburses municipalities for 80 per cent of general public assistance given and covers allowances for the mentally or physically handicapped, mothers with dependent children, and those who are not able to be self-supporting because of age.

Child welfare, adoption, and unmarried mothers' services are administered by the Province.

Provincial Comments

Our correspondents urged that further studies be done in each province because of provincial variations.

One correspondent writes as follows:

"I feel that the brief gives a good general picture of existing services, gaps in services, problems and needs in the four areas in which the survey was made. I think, as you have mentioned, that it is unfortunate time did not permit a similar survey being made in each province.

"I am attaching hereto an outline of observations I have made concerning various matters dealt with:

"While salaries now paid to qualified public health personnel are considerably better than those paid a few years ago they are still, in many cases, considerably below a level that will attract to and retain bright young men and women in the public health field. If the qualified personnel required to staff regional health and welfare units are to be obtained, provision must be made for a great increase in the number of scholarships available to such persons.

"In many cases today it is not possible to obtain experienced public health personnel as replacements for those retiring. Provision should be made to continue the services of well-trained and experienced personnel approaching the usual age of retirement where such persons are active and capable of rendering excellent service. The loss of highly skilled personnel still eminently capable of rendering fine service is one we can ill afford.

"In regard to the recommendation that all health and welfare services be integrated and consolidated in regional health and welfare units, such a programme has many advantages. However, many problems, local and provincial, would arise

as a result of such a programme. A great deal of education would be required in local areas as opposed to the advantages of such a programme before it was put in effect. There is a real danger of the welfare budget, especially in a rapidly expanding welfare programme, becoming so large as to completely overshadow the preventive health programme. Treatment service programmes are still much more popular with the general public and legislators than sound and well-conceived preventive health programmes. In my opinion, a number of pilot regional health and welfare units should be set up in selected areas across Canada and operated for a period of not less than five years in order to gain experience as to how such an integrated health and welfare programme would work out in metropolitan centres, smaller urban centres and rural districts, and outlying areas. This should be done before embarking on a Dominion-wide programme.

"Part-time public health service should be eliminated. Districts now served in this way should be merged with adjoining district health units or be set up as full-time district health units where the population warrants such a programme. More emphasis should be placed on the importance of a well-planned health education programme which should be carried on under the direction of a well-qualified health educator. A qualified teacher who has received special training in the field of health education or a public health nurse who has received similar training, with a flare for this type of work, can carry on an effective health education programme in all health units. There is still a vast amount of work to do in this field.

"The active interest and co-operation of local, provincial, and voluntary organizations and of the medical, dental, nursing, and teaching professions in the areas served is important. A regional health council, consisting of representatives of such organizations, which should meet at least quarterly, could be of great assistance in interpreting the public health programme to the community served and in acting in an advisory capacity to the local health authorities. The local health unit office should be located in a local general hospital wherever this is possible. This should also apply to the office of the local welfare department.

"The importance of retaining the active interest and support of the people served by the local health unit should receive much greater consideration. Without their active interest and support no health or welfare programme can be effective. Local municipalities included in district health unit areas should bear not less than one-third of the cost of providing health services and should, of course, be represented on district boards of health.

"Provision should be made for emergency bedside nursing care by members of the local health unit nursing staff wherever possible. Where the public health nursing staff is insufficient to provide this service, a co-operative arrangement should be made with a voluntary agency, such as the Victorian Order of Nurses. Public health nurses and hospital nursing personnel should be relieved of the great amount of work involved in the completion of health and hospital records and statistics. Much of this work could be done by competent and well-trained clerks and stenographers. There has been much talk but little action in regard to this matter.

"The Alberta programme for the training of nursing aides is, in my opinion, an example of a provincial programme which has made a tremendous contribution in providing the services of nursing aides to all hospitals requiring the same. Schools for such a programme should be operated only by provincial Departments of Health and nursing aides completing their training in such schools should work only under the direction and supervision of registered nurses.

"Much more consideration should be given to the training of persons in the home in home nursing and first aid, such as through the courses offered in this field by the Canadian Red Cross Society and the St. John Ambulance Association. With such a home nursing programme in effect, many persons now admitted to general hospitals and to hospitals for the more chronic types of illness could be cared for at home. The Junior Red Cross has recently issued a Manual on Home Nursing for use in connection with the Junior Red Cross programme in the schools and is making training in this field available. This programme has been well received and we trust will, in due course, be extended to all Junior Red Cross members in Canada.

"Hospitals for the more chronic types of illness should be located near the place of residence of those requiring these services and should be constructed adjoining a local general hospital. Many of such patients require the services and facilities of a general hospital from time to time. The Alberta programme in this field and that being developed in Saskatchewan are worthy of serious study. Good planning in this field is essential to avoid duplication of services and to provide efficient care of patients.

"The services of voluntary organizations in the field of health and welfare should be operated in close co-operation with the local health and welfare departments. Wherever possible the offices of such voluntary organizations should be grouped in one building adjoining the local general hospital and the local health unit.

"The importance of the mental health programme in the district health setup cannot be over-stressed. I feel that this programme should come under the supervision and direction of the provincial Division of Mental Health and should be carried on in close co-operation with the mental hospitals in the various regions served. A vastly augmented staff of psychiatrists, psychologists and well-qualified social workers will be necessary to implement such a programme. We are not even touching the fringes of this problem today, especially in the smaller urban centres, rural districts and outlying areas. The full co-operation of the provincial Department of Education and the provincial Welfare Department should be enlisted in this programme.

"I feel that the importance of developing a well-rounded industrial health programme should be urged in the brief. Such a programme should be developed under the supervision and direction of the Division of Industrial Health of the provincial Department of Health.

"The urgent need of developing a dental health programme in every health unit cannot be over-emphasized. The deplorable situation which now exists in respect of dental care cannot be changed to any material extent until the number of dentists in practice is increased by at least three times. With the full co-operation of the dental profession and with the employment of well-trained dental hygienists, a preventive dental health programme for children in the younger age groups might be developed, particularly in districts in which no dental service is now available. The travelling clinics which operated in Alberta in the early years made medical, minor surgical, and dental services available to an average of 24 of the more outlying areas each summer. By this means these services were made available to children urgently in need of such care.

"I feel that the importance of research in the field of public health and hospital administration should receive greater emphasis in the brief. Well-qualified personnel directing sound and well-planned research programmes can make a real contribution to public health and hospital administration and give a great stimulus to their associates on public health and hospital staffs. In the rapidly changing world in which we live, sound research programmes are of vital importance.

"If facilities for the proper training of the greatly increased public health, welfare, and hospital personnel required to provide an adequate public health and welfare programme in Canada are to be made available, it will be necessary to provide for a marked expansion of such facilities in our universities, the Schools of Hygiene, and teaching hospitals. Generous financial assistance will be required from Federal and Provincial Governments and various foundations for this purpose. Funds wisely expended for this purpose will earn dividends out of all proportion to the sum invested, both in the immediate future and for years to come."

Another correspondent comments on different items, as follows:

"Financing

"We suggest that the 60:40 sharing apply to rural areas as well as urban ones for public health services.

"Environmental Sanitation

"The situation described . . . is much the same as in Ontario.

"School Health Services"

"We feel that these should be mandatory.

"We agree with the trend away from repeated routine physical examinations, but we consider that routine physical examinations are of definite value on school entry.

"We entirely agree that the public health nurses should not be responsible for first aid in schools.

"Maternal and Child Health"

"We thoroughly agree with early notification of births to facilitate early home visiting and feel that this might be emphasized even more.

"Attendance at well-baby clinics in Alberta is by no means confined to lower socio-economic groups.

"Attendance at well-baby clinics in Alberta is by no means negligible after one year of age.

"Nurses"

"We thoroughly agree with the need for higher salaries for registered nurses and for incentives for post-graduate training and would like to see this emphasized more strongly.

"We agree with the principle of centralized training for nursing auxiliaries.

"Alberta has two schools for nursing aides, one in Edmonton and one in Calgary, both operated by the provincial Department of Public Health.

"Ambulance Service"

"We agree with the need for organized ambulance services.

"Home Care"

"We feel that there should be a clear distinction between home nursing services, which should be administered by health units, and homemaking services, which should be administered by the local welfare authority.

"Welfare Services"

"The need for trained social workers merits stronger emphasis.

"Voluntary Agencies"

"We agree with the need for better co-ordination in the activities of voluntary agencies.

"We entirely agree with the desirability of a closer relationship between health and welfare authorities.

"Regional Health Service Administration Suggestion"

"We agree with the principle of regionalization of health services, covering both hospital and community health services.

"We suggest that the chief executive officer should be a physician with public health training and preferably with extra training in hospital administration.

"Subject to a provincial minimum scale, salaries for administrators should be at the discretion of the regional board and not be dependent on the concurrence of contributing councils.

"Budgets should not be subject to veto by any municipality, even for permissive services if these are agreed upon.

"We agree with the idea of encouraging cross-use of specialized staff between hospitals and health departments.

"We recommend that the Medical Officer of Health be appointed as a member of the consultant staff of every hospital in the area of his jurisdiction.

"There are indeed some gaps to be bridged in this area, (i.e., relations among various community health services)."

BRITISH COLUMBIA

Public Health

Organization

The local public health services fall into broad groups:

There are local health units, each under a union board of health composed of representatives of the participating municipalities and school boards, which have united their local municipal and school health services to provide a generalized community health programme for the areas under their control. Professional, technical, and clerical staff of these health units are employed as provincial civil servants in order that there may be uniformity in programming and uniform personnel policies throughout the service. However, appointments and transfers are subject to the approval of the local Union Board of Health and, for practical purposes of day-to-day administration, staff are considered as locally employed personnel. The Health Branch, through the Bureau of Local Health Services, provides direct guidance and consultation service. The local school districts serve as tax collection agencies for raising a local *per capita* sum of 30 cents which is paid to the Province. The Province meets any additional operating costs from general tax revenues and National Health Grants.¹

There are metropolitan health departments for the metropolitan areas of Vancouver and Victoria under metropolitan boards of health which perform the same functions and carry on virtually the same programme for the two most heavily populated areas of the Province. Employment of personnel and appropriation of funds to finance these services are the direct responsibility of the city authorities. Through annual grants, the Health Branch contributes significantly toward the financing of each of these two health departments. In addition, it provides consultative and other services, including those of the Divisions of Laboratories, Tuberculosis, and Venereal Disease Control. In Vancouver, the Metropolitan Health Service is designed on the health unit principle. It is divided into unit areas, each with its own director, nurses, and sanitarians.

Throughout the health units, metropolitan or provincial, the health unit director is the medical health officer for all the cities, municipalities, villages, and unorganized territory within the area. He is also the school medical officer for the various school districts served by the particular health unit. Health unit personnel carry out a generalized public health programme. The services immediately available include communicable disease control, maternal and child health, school health services, preventive dental programmes, environmental sanitation, and health education. Specialized services in tuberculosis control, venereal disease control, laboratory diagnosis, mental health, occupational health, epidemiology, rehabilitation, vital statistics, nutrition, and public health engineering are available on a consultative basis from the various divisions of the Health Branch.

A number of the major voluntary agencies have contributed to the cost of building community health centres which are used jointly by them and the health units. These have become the health centres from which the health units operate.

¹*Per capita* local health service costs were approximately \$3.00 as of February 1963.

Sanitation

This consists of routine inspections and supervisory services related to food sanitation, restaurant catering, water supply, sewage disposal, nuisance complaints, and any other facets of the sanitary environment that may require attention. Consultative services are available from the Division of Public Health Engineering for special problems, particularly in relation to community water supplies, sewage disposal systems, stream pollution, swimming pools and beaches, and shellfish beds.

Communicable Disease Control

The local medical health officer is expected to be informed on all communicable diseases occurring in his area and each physician is required to notify him on those coming to his attention. Diagnostic tests and therapeutic and prophylactic drugs are offered as a service to physicians by the Health Branch through the health unit, which also distributes all the biological products used. Emphasis is directed toward immunization, commencing at the infant level and carried on through the pre-school and school years.

A rheumatic fever prophylaxis programme is available throughout the Province.

Tuberculosis Control

The local health units are charged with responsibility in tuberculosis control in co-operation with the consultative services provided by the Division of Tuberculosis Control. The staff members of the health unit arrange the schedules of travelling clinics, receive reports of diagnostic findings for residents of the local area, and assist in making arrangements for further care and continuing follow-up. Anti-microbial therapy, where necessary, is provided by the public health nurses attached to the health units, while an active tuberculin case-finding survey is maintained in co-operation with the British Columbia Tuberculosis Society, a voluntary organization which undertakes much of the publicity and education during those campaigns.

Venereal Disease Control

Case supervision and contact tracing is carried out locally in co-operation with the Division of Venereal Disease Control. This Division operates a full-time clinic in Vancouver. Part-time clinics are operated by the health units' personnel throughout the Province in various centres. These clinics offer free diagnostic and treatment services and, in areas where no clinic facilities are available, the Division enters into a contract with private physicians for the diagnosing and treating of indigent patients.

Maternal and Child Health

The public health nurses are particularly active in this field. They provide instruction to parents by home visiting and through prenatal classes for expectant parents. In the metropolitan centres the Victorian Order of Nurses assumes a major responsibility for this programme.

Post-natal visits are made to the homes for advice to the mother on post-natal care for herself and instruction on the care of the infant. As early as possible the mother is encouraged to bring the child to the child health conferences for continuing instruction on the handling of the child; at these conferences immunization is provided. The public health nurse will make home visits for

special circumstances, such as rheumatic fever prophylaxis, mental health, or to investigate accidental poisonings.

School Health Service

The Public Schools Act requires that each school board provide a school health service, but throughout the Province the school boards have transferred their jurisdiction over these services to the Union Boards of Health to arrange for provision of this service by the staff of the health units.

Basically, the programme is designed as a joint responsibility between the classroom teacher and the public health nurse. The programme is based on the assumption that a majority of school children are in satisfactory physical, mental, and emotional health. Special attention is devoted to those exhibiting some deviation from normal in order to encourage the use of remedial measures and to help the pupil to adapt to any handicaps which cannot be corrected. Regular teacher—nurse conferences are held as a means for screening those requiring service. Physical examinations by the school medical officer are conducted on referral from the nurse, except under unusual circumstances. The public health nurse makes regular visits to each school and conducts immunization programmes on a recommended schedule for the pupils, organizes routine vision screening assisted by the teacher, arranges routine audiometric testing for pupils in Grade I, plans tuberculin tests on a recommended schedule, arranges height and weight measurements for specific children, conducts home visits for children with particular problems, and serves as a resource person in the field of health education. A similar service is being developed at the kindergarten level. The classroom teacher is expected to observe and report to the nurse any deviations from the normal, to give health instruction, to foster desirable attitudes in the pupil toward his personal health, to apply minor first aid, to arrange transportation in metropolitan areas for pupils who become ill, and to consult regularly with the public health nurse, through the child health conferences, on health matters pertaining to the pupils under jurisdiction.

Laboratory Services

Laboratory service is provided by the Division of Laboratories through a central laboratory in Vancouver and two branches in Nelson and Victoria. These perform all types of tests and distribute biologicals free of charge through the health units.

Dental Health Service

The metropolitan areas of Vancouver and Victoria provide dental health services in dental clinics operated by full-time dental practitioners. Services are given to pre-school and Grade I children, including dental examination, treatment, and counselling to parents.

Outside the metropolitan areas different methods of operating dental health services have been tried. Services set up under local health unit administration with a full-time dental officer in each unit proved impractical because of a shortage of dentists. An alternative plan, locally sponsored and utilizing services of resident practitioners has been increasingly successful. In 1961, some 94 communities and 129 dentists were participating. The cost is shared equally between the community and the Province. The sponsoring group, which is in most instances the local school board, decides whether local registration or treatment may be free to parents or on payment of a nominal sum. The

programmes are directed primarily at pre-school and Grade I levels. To maintain liaison between the communities and official health agencies, regional dental consultants have been appointed by the Department of Health to advise on planning and carrying out local programmes. Emphasis is on preventive dentistry.

Hospitals and the Hospital Insurance Programme

The following is a tabulation of acute general hospital beds in use in British Columbia at the end of 1962:

8,673 beds in non-profit general hospitals,¹

76 beds in proprietary general hospitals,

545 beds (approximately) in federal hospitals.²

In addition there were 395 rehabilitation hospital beds in service, including 25 in federal hospitals. These include beds in special rehabilitation hospitals and rehabilitation units in general hospitals.

At the end of 1962 there were also 64 institutions licensed as private hospitals, involving 2,465 beds which were caring for patients who required nursing and periodic medical attention, but who were unlikely to recover.³ Although licensed as private hospitals, they are generally referred to as nursing homes, and are rendering nursing care under the supervision of registered nurses. But they provide little in the way of diagnostic or treatment facilities.

Active and rehabilitative standard ward hospital care on a province-wide basis are provided through the British Columbia Hospital Insurance Service, which was begun January 1, 1949, to provide protection against the cost of acute hospital care. The Plan is administered as a separate branch in the Department of Health Services and Hospital Insurance, with its own deputy minister. Government funds for the operation of all provincial health and welfare services, as well as the provincial share of the Hospital Insurance Service are provided from provincial tax funds.⁴ The Hospital Plan also levies a co-insurance charge of \$1.00 per day on patients. All aspects of the provincial hospital construction grants, consultation, inspection, and payment to hospitals for services on behalf of the beneficiaries, and all inclusive *per diem* rates are centred in the Hospital Insurance Service.

In-patient benefits include standard ward accommodation and all other available hospital services. A qualified resident receives in-patient benefits in the hospital, while, in addition, certain emergency and minor surgery benefits on an out-patient basis are provided at a charge of \$2.00 for each visit.

Tuberculosis and mental health care are not included in these hospitalization benefits but are provided through hospitals operated by the Provincial Government, in which patients who are able to pay are charged a maximum of \$4.50 per day for tuberculosis care and \$1.50 per day for mental health care.

¹Operated by lay groups, religious orders, municipalities, and the Province.

²This figure represents those beds in federal hospitals being used for general hospital care of a type coming within the scope of hospital insurance coverage. It does not include Department of Veterans Affairs beds used for service personnel, for those with pensionable disabilities, for those needing long-term and domiciliary care, etc., nor does it include beds in Indian Health Services hospitals used for the treatment of tuberculosis.

³These do not include the 76 beds in proprietary general hospitals noted above, which with one exception, are in hospitals operated by mining or other organizations in remote areas.

⁴The Social Services Tax of 5 per cent goes into the Consolidated Revenue Fund of the Province.

Home Care

Visits by public health nurses to provide nursing service in the home is carried out as part of the generalized public health nursing programme in the provincial health units and by the Victorian Order of Nurses in the metropolitan centres. These visits are dependent upon referral by a physician who is expected to supervise the service which is designed to provide nursing care to convalescent and chronic care patients. In so far as possible it is used as a demonstration nursing service from which it is expected other members of the household can gradually assume most of the nursing functions. Arrangements are under way for physiotherapy care as an extension of the programme. Homemaker services are also included in many cases in co-operation with the community welfare programme.

Mental Health

Mental health services are provided through a separate branch of the Department of Health Services and Hospital Insurance, with its own deputy minister. Mental health care is given through hospitals operated by the Province, in which patients able to pay are charged a maximum of \$1.50 per day. Homes for the senile aged are part of the mental health pattern, as are the facilities for defectives. A number of large general hospitals have psychiatric sections. Out-patient services and regionalized community mental health clinics in the community health centers have also been increasingly developed in recent years.

Rehabilitation

A rehabilitation programme is organized under the Provincial Co-ordinator of Rehabilitation and Registry Services. It is designed to carry out case finding and referral of handicapped to rehabilitation sources, to organize and maintain a vocational rehabilitation programme and to provide consultative services in the field of rehabilitation. It is expected to co-ordinate all the rehabilitation services throughout the Province. Within the Hospital Insurance Service, hospitals are encouraged to develop activation units for early rehabilitation of hospitalized patients while the development of "activation" care hospitals is also being emphasized in which rehabilitation, including physiotherapy, would play a large role.

Handicapped persons can be referred for active rehabilitative treatment, for fitting of prosthesis and re-adjustment to a new way of life to the G. F. Strong Rehabilitation Centre in Vancouver.¹ Where necessary vocational rehabilitation is undertaken.

In conjunction with the Department of Welfare, the National Employment Service, and the local health services, individuals in receipt of public assistance are being reassessed in certain areas to determine if some of them might not benefit from rehabilitation services. It has become evident that there are a number of recipients of public assistance who do require rehabilitation services and who can benefit to the extent that they can become independent producing members of society and no longer require social assistance. Wherever possible the services of the Unemployment Insurance Commission are used in finding employment opportunities for them.

¹This Centre includes the main service centres for several large voluntary agencies.

The Workmen's Compensation Board operates a large out-patient rehabilitation centre in Vancouver providing an integrated physical restoration and vocational rehabilitation programme.

The Health Department also provides a rehabilitation service to tuberculosis and mental patients and makes grants to a number of voluntary agencies serving the disabled. The Department of Social Welfare through its Family Division arranges for the provision of medical restoration service to disabled recipients of social allowances and selected cases for vocational rehabilitation.

A partial or complete rehabilitation service is supplied by voluntary agencies concerned with alcoholism, arthritis and rheumatism, blindness, cerebral palsy, cystic fibrosis, deafness, diabetes, epilepsy, mental defects, mental illness, multiple sclerosis, muscular dystrophy, myasthenia gravis, narcotics addiction, paraplegia, polio, and tuberculosis. One of the major voluntary agencies, the Poliomyelitis and Rehabilitation Foundation of British Columbia, sponsors disabled persons in need of medical and rehabilitation services and provides grants to develop new facilities. This agency and the British Columbia Society for Crippled Children are administered by a joint management committee and share certain facilities. The Provincial Rehabilitation Co-ordinator works closely with these voluntary groups.

Specialized medical rehabilitation facilities are available in larger hospitals, chiefly in Vancouver and Victoria. Physiotherapy and occupational therapy are offered in many general hospitals and chronic care institutions.

Provincial Comments

Several correspondents commented in considerable detail.

One writes:

"As might be expected, we find a great deal that merits study and examination. The concept of regionalized health services has much to commend it since it provides for integration of all the community health services, co-ordinated one with the other to provide the maximum benefit for each resident of the community. This we are sure is an ideal concept in which the community resources would be pooled to avoid overlapping, duplication and mis-spent effort in health programs throughout the community.

"There must, of necessity, be some consideration given to the size of the region and from our point of view in British Columbia we are inclined to think that our existing health units satisfy that definition. We could not recommend, from our experience, that several health units be included in a regionalized service as we feel that in so far as our Province is concerned it would become too unwieldy to be efficiently administered. Consequently, we would prefer each health unit to be regarded as an administrative unit to encourage integrated community health services in each community in which the official and voluntary agencies, including the hospitals, pool their resources in the interests of more effective health programs for the community.

"It would seem to us that, ideally, the medical health officer might develop as the administrator of such a service. Because of his training in medicine and in administration, he can readily be considered as fitted to co-ordinate the service. In effect, his interests are community directed in any case and he could endeavour to enlist the support of others in that interest.

"The basic area of difficulty would be to get organized medicine and organized hospital services to unite forces with official and voluntary public health services in a co-ordinated approach. It will require a great deal of tact and diplomacy on the part of

the regional administrator to develop and intertwine all those interests in a united approach. Initially, the plan might be best adapted to the smaller centres, since it will be a more formidable job in the metropolitan areas. At the same time, it must be recognized that apart from the regionalized program there are needs for specialized programs which can only be developed in the larger centres to which some of the regionalized programs must funnel specific cases for special needs.

"From our point of view, we can foresee that the development of such a plan would be a long time growing but it does present a design for the future worthy of study.

"With regard to your suggestion that a regional health service pattern would overcome many problems, we agree that this is a sound concept and as mentioned previously, we do feel that our present health unit organization lends itself to this definition.

"We cannot feel too happy about the third major component, namely the regional official welfare services, since we do feel that it is vital for public health to dissociate itself from any suggestion in the mind of the public that it is, in any way, an indigent medical service. As you are aware, the Departments of Health and Welfare became totally separated under their respective Ministers within the past five years in British Columbia and we do feel that this has been of considerable benefit to public health. Although we agree that these Departments have many fields in which their interest is identical, at the same time their basic purpose is quite different in that the welfare services are directed to certain groups of the population only, whereas public health services should be made available to and taken advantage of by all.

"The Regional Health Services Board outlined closely parallels our present Union Boards of Health, but, as mentioned previously, we do not feel that a suitable *per diem* payment should be recommended. In discussing the training and experience of the 'executive officer' we note that you would require that this man be a qualified physician. As we see it, in most of the less densely populated areas, this would automatically mean the medical health officer, since the administrators of the smaller hospital are invariably lay persons without medical training.

"We note further that you suggest that the executive officer and his deputy be appointed by the Regional Board, subject to approval by the Minister of Health and that he be directly responsible to the Regional Board in implementing the internal health service administration for the region. We agree that this is satisfactory with the proviso that these same officers be provincial civil servants and in this way, although responsible to the Board, they are not forced to abide by the Board's decision in any matter affecting the actual public health programs of their area. This attempts to maintain the balance between local autonomy on the one hand and excessive centralized control and lack of local responsibility on the other. Again, we appear to have arrived at a fairly satisfactory working relationship in this regard in British Columbia and want to make it quite clear that excessive local autonomy, just as much as too great a centralized control, results in poorer standards of service in the field.

"Continuing with the regionalized service... duly qualified dentists, often very recently graduated, are paid a salary to conduct preventive dental clinics and to treat private patients in the more remote areas of the Province under the supervision of the regional dental consultants attached to the nearby health units.

"In general, we agree with the ideas expressed on 'staffing' and would again point out that the lack of bedside care does not apply for public health nurses in this Province where a home care program is in operation.

"We were interested to note that *per capita* expenditures on local health services varied from 50c to \$4.10 in the areas under study. Today, in British Columbia, we estimate that our local health services cost approximately \$3.00 *per capita* of which only 30 cents is raised by taxation at the local level, the remainder being a subsidy

by the Provincial Government. As you suggest, this confirms that small population cannot support a satisfactory modern local public health service on the basis of municipal taxation alone. We do not, however, agree with the statement that municipal health departments as opposed to health units receive only limited provincial financial assistance, since generous grants are made to metropolitan areas by the Health Department using provincial funds. We agree with the conclusion that basic salaries of the regional health staff should come from the Province as mentioned but from the foregoing you will note that, if anything, we would suggest that the Provincial Government be prepared to underwrite a large share of the cost of local health services. We whole-heartedly endorse your view that part-time services neither have nor can be a satisfactory procedure and their inadequacy becomes more as each year goes by.

"We agree with regard to the tuberculosis control program where we have achieved close liaison as outlined. As regards the venereal disease control program, the physicians in British Columbia report to the local medical health officer and not directly to the Province. It is the responsibility of the local medical health officer to follow up contacts and see that they obtain treatment. At the same time he is also responsible for notifying the central office of the Division of Venereal Disease Control in Vancouver. We find that this arrangement preserves the anonymity so much to be desired in this program but permits of the more rapid follow-up of contacts and improves their identification and treatment in the local area. This is all important if any program of venereal disease control is to be satisfactory.

"With regard to environmental sanitation, we find a need for the revision of existing legislation as to standards and requirements and would wish to have included such matters as air pollution, radiation, etc.

"With regard to the school health services, we agree with most of the opinion expressed and would mention that in British Columbia our school health program was modified in 1962, so that the routine medical examination has now largely been discontinued so that increased emphasis may be placed on examination following referral. We do continue to make provision for routine examination where economic, geographic, religious or some other such circumstance renders the taking of the child to the private physician unlikely. As far as possible, we work in very close co-operation with the teachers and use them to carry out routine vision testing in the school. As pointed out, we also have experienced a slight decrease in the attendance at child health conferences. Once the initial course of immunization is complete, it is hard to reach the pre-school child. I do not think that this can be interpreted necessarily as reflecting a good economic level or relate it to the number enrolled in prepayment plans but it does mean that we should attempt to give increasing service to the kindergarten age group and thereby 'locate' the child once again at the age of four or five years before he enters school. At least this will serve to close the pre-school gap experienced in the past.

"Perhaps in Ontario the physicians in group practice would be prepared to set aside one complete afternoon for prenatal, post-natal, and well-baby care, so that public health nursing staff might attend to assist them during this clinic as suggested. In British Columbia, we feel that this would be impractical and that the average physician could not set aside such a definite period to be reserved for such patients. His work-load is already over-burdened with emergencies and the demands of those seeking every day consultation. You go on to suggest that the physicians might also be invited to use the facilities of the health centre and that this might serve to remove frictions between doctor and health unit staff. We wonder if our approach, whereby we invite local physicians to lecture in the course of our prenatal classes, is not equally good, less complicated, and productive of very satisfactory liaison. It is our feeling that specific payments for this type of care would do little to encourage doctors to provide this supervision. Either they are interested and willing to provide it now or they are not. Payment will make little difference. To employ specialists, as suggested, would be very expensive; and certainly in those areas which, because of their rather isolated

situation, presently fail to attract specialists, one would have to be prepared to pay them at least \$30,000 per year in order to lure them away from the larger centres. This seems a rather expensive form of government participation!

"The arrangements outlined for public health nursing bedside care parallel the organization in British Columbia. In the larger urban centres, the Victorian Order of Nurses undertake home nursing. The health units provide it elsewhere in the Province. Duplication of effort is, thus, eliminated and as far as possible the same type of service is offered. We have found that, in many areas, it is important to try and establish a 'home help' service in addition to the bedside care and that often the former is even more appreciated by the residents of the area concerned.

"To further relationship with other community services, you are already aware of the health centre construction program in this Province, and we do feel that this has done much to improve our liaison with the voluntary health agencies. Personally we do not see why one cannot 'liaise' very adequately with the local hospital without either being under one roof or even being formally regionalized into one administrative organization. The same applies to welfare. Frankly we wonder whether a large complex administrative set-up of this type may not prove to be less effective than one in which each of these services works side by side and in close liaison. People often feel that if you place a heterogeneous collection of workers into one barrel they will perform better. I think this hypothesis is open to considerable argument! Until such time as the hospitals become much more community orientated, they are in no position to operate a home care program. As we see it, the hospital would take responsibility for the patient from the acute through to the 'activation' phases of care. Thereafter, some of the patients might be discharged home and continue to attend on an out-patient basis, while others would be discharged to the home care program operated by the local health unit staff who should have the opportunity to benefit from direct consultation with the physiotherapist, occupational therapist, etc. As you are perhaps aware, we have a part-time physiotherapist presently on staff in one of our health units to advise the public health nurses on this specialized aspect of individual patients care for at home. This program has worked very well and we hope to increase the number of physiotherapists occupying such consultative positions in the years ahead.

"Mental health services need to be developed further by the provision of treatment services including psychiatric beds in the local general hospital and psychiatric care on an individual basis, and secondly, by the development of regionalized community mental health programs whereby a psychiatric team may work out of the local health unit as in British Columbia, utilizing the local resource personnel for case-findings and follow-up. These local personnel include public health nurses, welfare workers, probation officers, clergy, etc. This latter service must always involve the family physician and allow the psychiatric team to be utilized to the best advantage. These other resource personnel undertake screening roles wherever possible. There is no reason why the psychiatrist employed in the community-orientated program should not also give private consultation, if time permits.

"You draw attention to the problems created by lack of specialists in the smaller communities, and it is interesting for us to note here that this problem is gradually disappearing in British Columbia, since specialists are gradually seeking to enter practice in many of these more rural areas. This is not yet true of all areas but many which, a few years ago, lacked any type of specialist service can now boast a surgeon, obstetrician, or paediatrician. We feel that this problem will gradually tend to resolve itself. In addition, we are happy to note the efforts which many physicians in these areas are making to organize themselves, so that most hospitals having more than 60 to 80 beds now have a reasonably well organized medical staff with tissue committees, obstetrical committees, etc. Certainly the accreditation program does appear to have exercised a considerable improvement in this regard. In these outlying areas, both radiologists and pathologists have been encouraged to locate on a regionalized basis and there is no doubt that the appointment of a regional pathologist serves to bring about considerable improvement in the standards of medical care. The

continued development of group practice allows a specialist to locate as a member of the group in many areas where he could not survive on his own and would certainly have to do a considerable amount of general practice were he to try and do so.

"May we sum up by saying that, although there is much to recommend in the 'regionalized' concept, care must be taken to avoid incorporating areas of service which may operate on their own to better advantage provided adequate liaison is established and maintained. Finally, we do not see regionalization as perhaps the panacea for all ills."

A second writes on different items as follows:

"In the first instance, I feel it is somewhat wrong to endeavor to develop patterns for government and voluntary public health services at the local community level in Canada. The only services that have been looked at to any extent are those which exist in the Province of Ontario and these in four centres. The services that exist in other provinces in Canada are much different from those in Ontario, and although I am sure that you will point this out, it will have to be pointed out in very strong language. Otherwise, I am sure that some individuals will arrive at a gross misinterpretation. In addition to this, many areas in Ontario are serviced only by part-time health officers with practically no effort as far as regionalization is concerned. This gives a picture of services that is backward when compared to Saskatchewan or British Columbia. The very fact that both Saskatchewan and British Columbia are fairly well advanced in regionalization in the specific health fields could be lost in your over-all report.

"There is considerable discussion relative to provincial versus local employment. As you are aware, we have had experience both ways in this Province, and I am quite convinced that if you can keep a fair amount of local autonomy, which we seem to be able to do in this Province, then employment at the provincial level is much better. I am sure that you have many examples of the situation in Ontario, where the richer municipality is able to employ not only better but more personnel. A further advantage of provincial employment is that transfers are much easier. The staff has a definite advantage in that they can seek promotion away from their local level but within the Province without a loss of superannuation and other benefits. I agree with the broad concept that perhaps employment at the local level would enable one to function better, but I do not think there is much difference. I believe that the value of provincial employment outweighs this factor. Where you deal with salaries and the whims of local boards and councils, this merely validates my arguments.

"Shortages in the rural areas, as far as public health nurses are concerned, do not become too apparent if you have an over-all provincial policy of recruiting and you can place individuals where they are best required. You touch on home care here, and as you are aware, this is part of the programme in British Columbia. This also gets into the conflict that exists between the Victorian Order of Nurses and Public Health Nursing services, but this will be dealt with at a later stage.

"Where you talk of closer liaison among doctors in clinical practice, the sanatoria, the general hospitals, and the health department, it already exists in this Province due to the fact that we have our health units properly regionalized throughout the Province.

"Where you describe the situation that exists in the City of Toronto, I would certainly feel that you should emphasize the point that such a situation does not exist in other large cities in this country, such as Vancouver.

"Services under provincial regional laboratories, working in close co-operation with local health services and the pathologists in the Province are already being fairly rapidly developed. A similar situation exists to a small extent in the field of radiology though not as marked since we do have more radiologists in the private practice. Therefore, although regionalized services, such as in pathology, would be desirable, they are not too feasible at the moment.

"I would feel that you could make some mention that some of the leadership in the regionalization and usage of beds should be given at the federal level. I think too many people forget that the Federal Government has a very high stake in the future number of beds in this country. I do not refer to their small contribution as far as construction is concerned, but more to the over-all operational cost from year to year.

"You talk in further detail about a regional health service. This is being gradually developed within the Province, particularly as it relates to public health and mental health. The regionalization and the closeness of association with hospitals is not as marked at present. It may be desirable, but I am sure it will be a long time in coming.

"Our services, as far as rehabilitation facilities are concerned, are co-ordinated with our local health departments throughout the Province.

"You talk of the public health nurse not participating in home nursing to any extent. This is not correct in this Province, since home nursing is part and parcel of our public health nursing services in most areas. I would again point out that you should mention somewhere the conflict and duplication that exists when you have both the Victorian Order of Nurses and public health nursing in the same community.

"Our union boards of health, on a smaller scale, represent what you are talking about as far as regional health services boards are concerned. They are, however, not as extensive, but I would concur with your thinking. I would be surprised if many people would buy the idea of a suitable *per diem* payment for time spent in this work. I agree that travelling expenses should be necessary, but to suggest that people should be paid for this, I think, would perhaps defeat the theory that there has to be a good deal of voluntary effort, as far as health services are concerned."

A third correspondent writes:

"In broad terms, and after only a preliminary reading of this report, I find it most difficult to offer any constructive comments. As you have stressed throughout this report, the conditions which you have studied are those in the Province of Ontario. . . . Conditions are vastly different and solutions that may be applicable to the Province of Ontario are not necessarily true for the Province of British Columbia. The whole public health set up is so vastly different in the two Provinces. If one, for example, looked at the structure of the provincial Department of Health in this Province, one would find that it also embraces the whole area of prepaid hospital care. Further, the financing of local health services in this Province is entirely different, where the employees are provincial civil servants but are subject to local control, and where the financing of local health units is on the basis of school districts, and where the major contribution comes from the provincial government. As another example of the differences encountered, the Department of Preventive Medicine in the university has become, in effect, a research arm for regional hospital planning in the metropolitan area of the lower mainland of British Columbia. This particular area embraces about half the provincial population. This has been done with the wholehearted co-operation of the Hospital Insurance Service of British Columbia.

"Four separate studies in this regard on hospital utilization have been completed and another one is under way at the present time. In the field of rehabilitation the director of the School of Rehabilitation at the university, which is a function of the Faculty of Medicine, is also the consultant in rehabilitation to the provincial Department of Health. In the field of maternal and child care, the Professor of Paediatrics is a consultant in that capacity to the provincial Department of Health.

"I simply use these examples that I have cited above as proof of the different conditions that exist in British Columbia as compared to Ontario. I am not for a moment suggesting that our organization is any better. Indeed, we have many deficiencies. However, I think to be of real value to the Royal Commission, one would have to take into consideration these varying conditions in each of the Canadian

provinces. I don't think that any general recommendations based upon one province alone would necessarily be applicable to the other provinces concerned. It may be that the comments you receive may allow you to incorporate the differences into your final report.

"I feel that this is a very well-done report with particular applicability to conditions as encountered in Ontario."

A fourth correspondent writes in detail, as follows:

"In regard to the hospital field, consideration has to be given to the different types of ownership prevailing in hospitals across the country. In British Columbia about one-quarter of the public hospitals are church hospitals. The balance, with the exception of two municipal hospitals, are owned and operated by non-profit community societies. In Alberta and Saskatchewan there are very few hospitals operated by community societies or like organizations, the great majority of the non-church hospitals being owned and operated by municipalities or cities and so forth. In Manitoba some of the non-church hospitals are owned by municipalities or cities and some by societies. The same would prevail in Ontario. In Quebec there would be a much higher proportion of church hospitals. The difference in ownership would have a considerable bearing on the acceptability of a regional health services organization since certain phases of administration by a regional body which might be acceptable to a lay hospital might not be to a church hospital, and again a hospital society or like organization, or even a church hospital, could much more freely delegate powers to a regional organization than could a city or municipally owned hospital, because of its direct responsibilities to the municipal or civic corporation.

"It is my opinion also that any arrangement for evaluation or co-ordination of health services is likely to be ineffective unless it has the active participation of organized medicine. In the operation of our Hospital Insurance Service we found it necessary to enlist the active support of the medical profession. By arrangement among themselves, the three representative groups, the Canadian Medical Association, British Columbia Division, the College of Physicians and Surgeons of British Columbia, and the Faculty of Medicine, the Medical Association was designated as the organization through whom representations and discussions could be channelled. An informal advisory committee was set up representative of the medical profession, the British Columbia Hospital Insurance Service, and the Health Branch of the Department. This has proven extremely valuable. Consideration is being given to the most suitable working relationship with hospitals. There is already in existence a Metropolitan Hospital Planning Council in Greater Vancouver representative of the hospitals, the medical profession, and of municipal and civic bodies, with non-voting representation from the Hospital Insurance Service and the provincial Health Branch. It has been found that very few metropolitan studies can be confined to the metropolitan area, as consideration has to be given to the needs of the entire Province because of the volume of referrals. The hospitals themselves have suggested the expansion of this to a province-wide body, and it is possible that an arrangement like that will result, closely co-ordinated with the medical advisory committee previously mentioned.

"In British Columbia home nursing and home care programs are linked together. Home nursing can often break down unless there is provision for other fortification in the home, and quite often again there is necessity for the patient to be taken periodically to treatment services or for treatment services to be taken to the patient. Home nursing or home care programs are by arrangement under the general direction of the Public Health Service of the Province. In some areas the home nursing is provided by the Victorian Order of Nurses and in others by the Public Health nursing staff. The important thing is that, under this arrangement, a patient discharged from a hospital can, without difficulty, be referred to the home nursing or home care service in even a distant part of the Province. The principal fault that I have seen in hospital-based home care programs is that, if the patient comes from outside the immediate area of the hospital, he does not come under the home care program, and similarly if a patient from that hospital area is hospitalized elsewhere, he does not readily fit into the home nursing program.

"You mention medical staffs and the absence of qualified specialists outside large urban centres. This is not the picture in British Columbia. Very frequently we have representations from hospital groups for additional diagnostic and treatment facilities, supported by evidence of the location of specialists and qualified surgeons in the area. As a result of this and the construction of new hospitals, there has been a definite reduction in the percentage of patients referred to the metropolitan areas.

"With regard to the problem of an adequate supply of registered nurses, there are a great many married nurses in British Columbia who work either part-time or full-time. However, there are not enough nurses graduating to meet future needs, and we have to depend on a flow of nurses from elsewhere in the country. It is essential that there be either an expansion of existing schools or development of new schools of nursing. The existing schools are close to their capacity to absorb students in the usual pattern of training, although there can be some expansion. It would seem that there will have to be other schools opened or arrangements made for nurses to receive part of their clinical training in large hospitals and the balance in selected medium-size hospitals. One of the problems has been the trend of the Registered Nurses' Associations to upgrade requirements for nursing education. I have, for example, noted in some quarters considerable hostility to the program of a central school and the use of smaller hospitals, such as prevails in Saskatchewan. Undoubtedly the drive to upgrade nursing education has been most necessary, but in British Columbia at least, there may have been too much insistence on large schools without sufficient attention to the possibility of providing, by a combination of efforts, acceptable training in medium-size hospitals.

"With regard to rehabilitation facilities, we have had some very interesting developments in British Columbia. Every step taken has been worked out with the advice and guidance of the medical profession. An Associate Professor of Medicine at the University of British Columbia, serves as advisor to the Medical Consultant of our Service in the rehabilitation field. Hospitals are encouraged to establish rehabilitation units. In some instances these are units of from eight to twelve beds, depending on the size of the hospital. Such services must be carefully co-ordinated with home nursing services and with rehabilitation programs in the Province."

GENERAL APPLICATION OF THE ONTARIO FINDINGS AND SUGGESTIONS TO THE OTHER PROVINCES

The project method has been outlined in the preface, together with the reasons for doing field studies in one province only.¹ It is clearly recognized that differences in health service patterns exist among the ten Canadian provinces.² Most, for example, provide local public health services, except for large cities, through provincially organized and operated health units and districts. Regional public health, hospital, and other organized health service patterns have been extensively developed in some provinces, for example, Manitoba and Saskatchewan, or are being considered at present. Some provinces have greater integration of organized health services than have others, for example, Newfoundland. In other words, each province has patterns of organized community health services which have evolved from its own particular geographic, social, economic, population, and cultural circumstances.

In this study and report, no pretense is made that the situations in the other provinces have been considered in the detailed manner which has been possible for Ontario. However, it is our contention that the following general observations on Ontario, made in Chapter IV of this study,³ hold true for all provinces:

"Scientific, social, and economic changes are making the traditional pattern of separately developed and administered community health services less and less efficient. Circumstances have combined to create a rapid proliferation of health services of ever increasing complexity. The resultant overlapping of services in some areas, gaps in services in other areas, and uneconomic use of skilled personnel and complex facilities, are hampering the ultimate objective of providing a balanced pattern of modern community health services which work together effectively. Segregated community health service planning and administration should be ended."

Though most of those in the different provinces to whom the working document was sent favoured closer formal co-ordination of all organized health services at the regional or provincial levels, a few were opposed to the idea of a common administrative structure for all organized health services.⁴ Their preference was for separate administrative patterns, as they presently exist, with liaison and co-ordination to be facilitated through such means as joint committees and cross-appointments. It is clear from some of the comments received and

¹Preface, pp. I-V.

²See Chapter VI, pp. 91-166, for factual summaries of organized health services in the provinces other than Ontario.

³See pp. 69-73.

⁴Comments received are presented in Chapter VI, pp. 91-165, following the factual description of services in each province.

from conversations from time to time with colleagues from other provinces, especially those working at the community level, that, whereas in Ontario problems arising from a high degree of local autonomy exist, in provinces with quite limited local autonomy in such services as public health, problems arising from over-centralization of planning and administration may occur. On the other hand, some of those to whom the working document was sent favoured retention of almost complete provincial administration of public health and some other programmes, for reasons of greater administrative ease.

After consideration of existing organized health service patterns, the various comments and suggestions of those in each province to whom the working document was sent, and our own knowledge of the different provinces,

it is suggested that a co-ordinated regional approach to the planning and administration of organized community health services be implemented in each province, comparable in general concept to the suggestions made for Ontario in Chapter IV,¹ but subject in precise details to the particular circumstances and traditions of the specific province.

Thus, for example, it would seem wise to consider all of Prince Edward Island as one region. Provinces of moderate size but with relatively small populations, such as Nova Scotia and New Brunswick and, in time, possibly Newfoundland, might wish to have more centralized general administration of some services than has been suggested for Ontario, with semi-regional divisions for other more extensive services, such as hospitals and public health services. The Prairie Provinces and British Columbia, because of their large areas and relatively large populations might well consider two or more regions each though to conform with existing administrative patterns they might wish to retain greater provincial powers than have been suggested in the case of Ontario. In Quebec and Ontario, with both large areas and large populations, a number of regions seem indicated.

Special interprovincial agreements would be desirable, so that an area in one province with an obvious referral pattern to a large centre in an adjoining province could continue and extend existing largely *ad hoc* arrangements on a more organized basis, as for example, the Kenora section of Ontario to Winnipeg in Manitoba. Highly specialized facilities and personnel, such as special rehabilitation centres, might well serve several adjoining provinces with relatively small populations individually, as for example, the Maritime Provinces.

It is also obvious from our own knowledge of provinces other than Ontario, from a consideration of the factual summaries in Chapter V² of organized health services in the other provinces and from the comments and suggestions of those to whom the working document was referred in the other provinces, that many, if not most, of the specific health service problems and issues found in Ontario

¹Chapter IV, pp. 69-73.

²Chapter VI, p. 91.

exist to a greater or lesser degree in every province. Problems and issues of planning, distribution of services, education and training, staffing, financing, and co-ordination are not peculiar to Ontario.

It is suggested that comparable studies to the ones described in this study be carried out in the other provinces, so that the specific application of the main administrative suggestions, as outlined in Chapter IV,¹ and of the specific service and programme suggestions, as discussed in Chapters I to III² and as summarized in Chapter V,³ may be determined for each province.

¹Chapter IV, pp. 69-73.

²Chapters I-III, pp. 11-68.

³Chapter V, pp. 75-87.

APPENDIXES

CITY OF PETERBOROUGH FIELD STUDY

SOME GENERAL FACTS

The City of Peterborough is located in the County of Peterborough about 90 miles north-east of Toronto and 135 miles west of Kingston. It is the administrative centre of the county and the largest urban centre for a considerable distance in all directions. The Otonabee River, a part of the Trent Canal system linking Lakes Huron and Ontario, flows through the city. Geographically, Peterborough is situated in the St. Lawrence lowland region. A fertile agricultural region immediately surrounds it. To the north are the wooded highlands and lake country of the Canadian shield. To the east is an area with large mineral deposits of iron, uranium, and nepheline syenite. The climate is warm in summer and only moderately cold in winter.

Historically, the site was first called Scott's Plains after the man who built a grist mill there in 1820 to serve the settlers, chiefly from England, who came to the area because of land grants offered to retired military personnel following the Napoleonic Wars. A few years later, a large number of Irish immigrants came to the area to farm. The rich timber resources of the surrounding area served to encourage the growth of sawmills. The name, Peterborough, was given to the settlement in 1827. It grew steadily as the centre for the surrounding farming and lumbering activities.

The 1961 Census figures showed a population of 47,185 people as compared with 38,272 in 1951, an increase of over 23 per cent in the decade.¹ Approximately 100,000 live within a 20 to 25 mile radius of this city. A recent annexation on January 1, 1963, raised the city's population to just over 50,000 people. Of the 1961 population, almost 40 per cent were under 20 years of age, as compared with 39.5 per cent for the Province as a whole.² Approximately 9.3 per cent were 65 years of age or more, as compared with the provincial figure of about 8.3 per cent.² The somewhat higher proportion of older people exists to a large extent because older people from the surrounding rural area often come to the city on retirement. Over 80 per cent of the people are of British Isles stock. The remainder are largely European in origin. Approximately 70 per cent are Protestant and 24 per cent Roman Catholic in religion.

¹Dominion Bureau of Statistics Census data for 1951 and 1961. The percentage population increase for Ontario as a whole over the same period was 35.64 per cent (from 4,597,542 people to 6,236,092 people).

²Dominion Bureau of Statistics 1961 Census data.

Peterborough is a large manufacturing centre. The largest industry is the manufacture of electrical equipment.¹ Other large industries are producing electric appliances, outboard motors, farm machinery and iron products, power lawnmowers, chain saws, watches and clocks, flour, feed, cereals, and bakery products, rugs and carpets, boats and pleasure craft, paper products, lumber and building supplies, and until recently meat packing. Peterborough is also a centre for the marketing of the farm products, especially dairy products, of the surrounding rural area. The tourist trade is an important source of revenue because of Peterborough's location in the heart of a lake and resort area.

The City is well supplied with electric power, with a capacity in excess of the present usage, and with natural gas. Water for drinking and commercial purposes comes from the Otonabee River in more than sufficient amounts. Extensive underground water supplies also exist.

The Canadian Pacific Railway provides daily passenger, freight, and express services to Toronto and elsewhere. The Canadian National Railway has daily freight and express services. Highway No. 7 between Toronto and Ottawa goes through the city and there are good connections with Montreal and other centres. There are daily bus connections to Peterborough and quite a number of transport companies serve the city. There is a private airfield just south of Peterborough.

The cost of living is generally similar to that elsewhere in southern Ontario, though slightly lower than for Toronto. Shopping facilities of all types are good. There are good public and separate primary, technical, and secondary schools. In addition, there is a provincial teachers' college. A new liberal arts and basic science university, Trent University, began accepting students in the autumn of 1963. A large daily newspaper and a small weekly newspaper are published in Peterborough. There are two radio stations and one television station. The city is administered by an elected mayor and ten aldermen through full-time municipal departments.

PUBLIC HEALTH

Organization

The City of Peterborough has a full-time Public Health Department. The Board of Health² consists of four members, only one of whom, the mayor, is a member of the Municipal Council. The Secretary is the City Clerk. The Medical Officer of Health is a member of the Board as well as its chief executive officer. The Department has its office in the City of Peterborough Municipal Building.

Abbreviated Financial Statement, 1962³

Revenue	
National Health Grants	\$ 9,066.01
City of Peterborough	79,609.46
	<hr/>
	\$88,675.47

¹The main plant of Canadian General Electric, Canada's largest manufacturer of electric equipment.

²1962 Board of Health:

The Chairman—a business executive.

The Mayor of Peterborough.

A retired school principal.

An employee of Canadian General Electric Company.

³The actual expenditures were approximately \$14,500.00 less than budgeted for, chiefly because the staff was below strength for part of the year.

Expenditures

General Administration	\$ 3,062.05
Health Education	499.22
Miscellaneous (including conferences, rentals, etc.)	3,663.23
Salaries	75,242.46
Transportation	5,168.53
Contingencies	1,039.98
	<hr/>
	\$88,675.47

Staff¹

	Full-time	Part-time	Total
Medical Officer of Health	1		1
Other Physicians		1	1
Supervisor, Public Health Nursing	1		1
Public Health Nurses ²	10		10
Chief Sanitary Inspector ³			
Secretarial and Clerical Staff ...	3		3
Sanitary Inspectors ⁴	2		2
	<hr/>	<hr/>	<hr/>
	17	1	18

About one-half of the public health nurses are married and, though there is reasonably high turnover, replacements are fairly readily obtained. The public health nurses are hired by the Board of Health, with automatic City Council approval. Salary ranges are comparable to those in urban centres of comparable size in Ontario.⁵ They receive an annual four weeks vacation. In-service conferences and teaching sessions are held for the nurses and, in addition, there are opportunities to attend outside courses and conventions.

The sanitary inspectors are employed directly by the municipality on recommendation of the department, and are members of the City Hall Employees' Union. A personnel problem exists because under the agreement between the city and the union the sanitary inspectors receive larger salaries⁶ than the present maximum salary for the public health nurses. This agreement has also caused concern because the holiday time for inspectors has been reduced to two weeks from the four weeks available when they were employed directly by the Board of Health. At present there is no specific in-service training programme for the sanitary inspectors.

Programmes

Communicable Disease Control

GENERAL

Reporting in general is incomplete but the major diseases are well reported.⁷ Certain childhood communicable diseases are well reported by the

¹As of the end of 1962.

²Two of the nurses were partly financed through National Health Grants.

³As of 1963 there is a Chief Sanitary Inspector.

⁴A trainee sanitary inspector is being sponsored by the Department.

⁵As of 1962, starting salary was \$3,650.00 per year. Annual increments to a maximum of \$4,400.00 with an additional \$100.00 for a nurse with a university degree. Salary for Nursing Supervisor in 1962 was \$5,200.00.

⁶As of 1962, the lowest salary was \$4,600.00 per year. Annual increment to a maximum of \$4,900.00. The range provided for a Chief Inspector was \$4,750.00-\$5,350.00 per year.

⁷There were 85 infectious hepatitis cases reported in 1962, compared with 32 reported in 1961.

schools and to a lesser extent by the doctors. No routine visit is made to home where a communicable disease has been reported unless there is some reason indicated for such a visit. Enforcement of isolation periods so far as school re-entry is involved is left to the school principals.

The Medical Officer of Health is a member of the Hospital Infection Committee at St. Joseph's Hospital. This Committee meets monthly except during the summer and reviews all infectious cases to decide if they arose in the hospital or were brought in from outside. Attempts to prevent future outbreak are carried out.

TUBERCULOSIS CONTROL

Regular diagnostic and follow-up clinics are held at St. Joseph's Hospital and the Civic Hospital². The City Health Department provides a public health nurse for each clinic. A physician from the Tuberculosis Prevention Division of the provincial Department is present at one clinic each month to carry out referral examinations. The two other clinics are staffed by public health nurses only.³ In the spring of 1963, the programme was increased to four clinics a month with a physician at each clinic. Two are held in the Civic Hospital and two in St. Joseph's. Two of the clinicians are from the provincial Department and two are local physicians. One full-time nurse is employed by the clinic. The clinic and the nurse provide some increased service for the area immediately outside the city. The cost of the increased service is paid for by the Division of Tuberculosis Prevention of the provincial Department of Health. All referrals to the clinics are made through the Peterborough Health Department. The X-ray equipment is provided by the province and the hospitals provide the X-ray technicians and necessary space. The cost of X-ray films is covered by the Peterborough County Tuberculosis Association.⁴ A volunteer from the Peterborough County Tuberculosis Association also assists in operating the clinics. Most patients requiring sanatorium care are referred either to the sanatorium in Kingston or the one in Weston (Toronto). The Association covers transportation costs if these cannot be arranged personally.

Miniature chest X-ray units have also been installed in the two hospitals for use in admission X-rays.⁵ If a larger film is indicated, this is done. The hospitals provide the technicians and space and are reimbursed by the Peterborough County Tuberculosis Association.⁶

So far, the Health Department has not felt it to be necessary to have an X-ray unit at its own office. The Department has been active in arranging for high risk groups, such as old cases, contacts, positive tuberculin reactors in younger age groups, and referrals from family physicians.

The mobile van of the Ontario Department of Health visits the old peoples' homes regularly. The medical officer of health has suggested that this procedure in old peoples' homes could well be modified to an initial admission X-ray and

¹Twice a month.

²Once a month.

³The public health nurses try to see all patients discharged on drug therapy once a month either at the clinics or in their homes.

⁴Through the Christmas Seal Campaign. See also p. 214.

⁵The 1961 admission X-ray rate at the Civic Hospital was 88 per cent and at St. Joseph's was 89 per cent.

⁶Fifty cents per film.

periodic sputum tests thereafter. The provincial Industrial Hygiene Division arranges for periodic X-rays of workers exposed to silica dust. A periodic mass survey is carried out in Peterborough approximately every four years using the nobile van service. Any resident may take advantage of the service. The present procedure is to do a miniature chest X-ray on all those over 40 years of age and a tuberculin test with subsequent X-ray if indicated on all people under 40 years of age. A number of the industrial firms require a pre-employment chest film. The Peterborough County Tuberculosis Association pays for the films.¹ The city Health Department does Heaf and tuberculin testing in the schools,² for the personnel working in nursing homes, and for those attending baby sitters' courses.

Since 1956 anyone in Ontario applying for either provincial or municipal allowances or welfare assistance may have a chest film at the expense of the provincial Department of Health. It is planned to encourage greater use of this procedure through the municipal welfare officer.

There is little question that, as elsewhere, the tuberculosis control programme is one of the most satisfying personally to the Health Department staff and is an area of close liaison with other community health services. One problem is that there are no full-time medical officers in the county outside the city. All reports on discharged patients are sent to the Health Department but its area is confined to the city proper. It is felt by the staff that a complete follow-up clinic and public health nursing service are needed in the county as well.

VENEREAL DISEASE CONTROL

The programme is largely one of following up contacts and those who are delinquent in taking treatment. There are no public clinics. If a contact is named, word is sent by the provincial Division of Venereal Disease Control to the Medical Officer of Health. The person is visited and required to go for a check-up.

There is some difficulty in obtaining accurate data on the actual incidence of venereal diseases in the area. Reporting is directly to the Province and by the Province back to the local Medical Officer of Health. It is suspected that some, perhaps even many, cases are now being treated without being reported.

IMMUNIZATION

Primary immunization by the family doctor is encouraged in the pre-school period in an effort to have all children start school with primary immunizations. At the child health clinics³ initial immunization and reinforcing doses of smallpox vaccine and the quadruple antigen⁴ are also given. A physician employed part-time by the Department gives the inoculations. During the 1962-63 season, initial doses and smallpox vaccinations were given in Grade I to those not previously immunized, as well as booster doses to those who had been protected. Henceforth, all primary immunizations will be done during the pre-school

¹*Ibid.*

²See p. 182.

³See p. 181.

⁴DPT Polio—diphtheria toxoid, pertussis vaccine, tetanus toxoid, and poliomyelitis (Salk) vaccine in a combined antigen.

period. A booster of triad vaccine¹ in Grades III and VII and a re-vaccination in Grade VII will be given.

In the secondary schools, a booster dose of combined tetanus toxoid and poliomyelitis (Salk) vaccine will be given in Grade XI.

No specific adult vaccination programme is provided. However, adults may come by appointment to the Health Department for vaccination against small pox. Those wishing other inoculations are referred to their family physicians. The original Salk vaccine programme was carried out in the area by the Department. The mass programme for the first Sabin vaccine dose was completed; 85 per cent of children and 55 per cent of adults were covered.

Sanitation

WATER SUPPLIES

The water supply is drawn from a surface source, the Otonabee River. The water is filtered and chlorinated in a plant operated by the Peterborough Utilities Commission. The potential capacity is well in excess of current demand. There are also large sources of underground water which could be used by industries wishing to have large amounts of unchlorinated water for manufacturing purposes. A fluoridation plebiscite in December 1962 resulted in a majority negative vote. The role of the Health Department is to do routine inspections on the safety for health. Municipal supplies are sampled daily and on request. No private supplies for drinking purposes exist in the city.

SEWAGE DISPOSAL

There is an adequate activated sludge with digestion sewage treatment plant operated by the municipal Department of Public Works. The excess sludge is trucked to fields in the surrounding county. In the summer the effluent is chlorinated but otherwise it passes without treatment into the Otonabee River. There is sufficient capacity for a number of years in the future. This plant can now handle industrial waste and every endeavour is being made to get all the plants in the city to use the sanitary sewer system rather than to put their waste into the storm sewers. Large users present no problem but some small domestic plants put waste into the storm sewers. Often they are unaware of this because the sewer connections were made many years ago and no one knows whether the connection is to a storm or sanitary sewer. The situation is detected only when extensive search is made for sources of pollution.

The Health Department's role is to make regular checks to be sure that pollution, which is hazardous to health, does not exist, as well as to investigate specific complaints.

The control of private sewage systems, septic tanks or privies, is also a department responsibility. Every effort is being made to eliminate the few remaining ones as quickly as possible. However, it is sometimes difficult to enforce by-laws about the required joining to sanitary sewers, when these are available. The city will offer to install and pay for the system and then let the owner repay the cost on an instalment basis with his taxes.

¹DT Polio—diphtheria toxoid, tetanus toxoid, and poliomyelitis (Salk) vaccine in a combined antigen. This is used for booster purposes only.

MILK SUPPLIES

There are seven pasteurization plants in the city. All control is through the dairies. These are checked twice a month by the Health Department for pasteurized milk samples. The Health Department does not inspect the farms of producers since these are inspected by the local representative of the provincial Department of Agriculture. An ice cream plant at one dairy is checked monthly.

SLAUGHTER HOUSES AND MEAT INSPECTION

All meat sold in the city must be inspected either by federal or provincial, or local authorities. This last requirement is under a new local by-law which requires all meat supplies sold for human consumption to be checked on. There are no slaughter houses in the city now. A large packing house has recently closed for economic reasons. There is a weekly farmers' market which is checked for general sanitation periodically.

FOOD OUTLETS AND RESTAURANTS

Bakeries, beverage rooms, butcher shops, eating establishments, food stores, ice cream vendors, markets, milk product plants, milk vendors, mobile canteens, pushcart vendors and pedlars, and refreshment booths are checked regularly for general sanitary conditions, as well as when they apply for annual municipal licences and on receipt of a complaint. There are four beverage and bottling plants in the area which are checked quarterly. Automatic equipment, such as food-vending installations and milk dispensers are also checked regularly. Soft ice cream plants are checked monthly when in operation. Visits are also made on receipt of complaints.

Restaurants and hotel dining facilities are inspected thoroughly monthly. Tests are sent to the provincial Branch Laboratory in Peterborough.¹ When they are visiting the restaurants and hotel dining rooms, the inspectors try to do some health teaching of proprietors and food handlers. The rapid turnover of employees in the food-handling field presents difficulties for health education and control. The aesthetic appearance of some facilities is not all that it might be, but this is not a Health Department responsibility unless health hazards exist.

PLUMBING

Plumbing control is the responsibility of a special Plumbing Inspector in the City Engineer's Department. As mentioned above,² the Health Department does inspect septic tanks and also the sanitation facilities in schools.

SWIMMING AREAS

Swimming areas on the river, canal, and a small lake inside the city are checked weekly during the season for swimming safety. Other areas are inspected monthly. One outdoor public pool is checked weekly during the summer season. Public indoor pools are inspected weekly. Private pools are checked on request only.

¹See pp. 194-195.

²See p. 178.

GARBAGE

Garbage collection is carried out by the City Engineer's Department. Garbage must be properly wrapped and placed in regular garbage cans. Sani-van trucks are used. Twice a year there is a special collection of any material which otherwise would not be accepted. This law is strictly enforced. Disposal is through sanitary land fill in Otonabee Township 10 miles away. The Health Department is concerned only with assisting in checking on complaints where a health hazard may exist.

HOUSING

A few areas of substandard housing exist. The present policy, where premises are to be condemned, is to wait until the people move out, and then placard them, rather than while being lived in. Not uncommonly the problem is to find housing for the former residents. Housing by-laws are co-operatively enforced by several municipal departments.¹

AIR POLLUTION

This presents no serious problem at present. There is a testing unit from the provincial Industrial Hygiene Division in the city. It is supervised by the Municipal Fire Department. Interest is chiefly in radioactive substances and dirt. The local Health Department is not directly involved. There is no local by-law under the Air Pollution Control Act but an inspector with the City Engineer's Department is doing some survey work.

MISCELLANEOUS

A variety of other premises are inspected regularly for sanitation purposes; for example, barber shops, beauty parlours, day nurseries, funeral homes, garage wash rooms, infant boarding homes, jails, laundries, lodging houses for tourists, schools, theatres, and public halls. Apartments are checked only on receiving a complaint.

GENERAL

One of the sources of difficulty is that some existing provincial legislation is difficult to enforce. Sometimes this is because of the general language in which it is written but also in some cases because of the personal hardship which may be involved in too rigid enforcement. Therefore, a good deal of tact has to be used in enforcing legislation. Otherwise, there are few environmental control problems that cannot be met by the city Department of Health.

Maternal and Child Health

PRENATAL PROGRAM

Four series of prenatal classes were conducted in 1962. People come on referral from their own doctors or must ask permission. Each series consists of nine sessions. These are operated by the Department of Public Health and are presented by the public health nurses. Physical exercises are also taught. During 1962 there were no classes for couples. It is felt that these classes are a preparation not just for labour but for parenthood.

¹Department of Health. Building Inspectors of the City Engineer's Department and the Fire Department.

There are no prenatal clinics in either hospital nor does the hospital provide clinic service. Medical prenatal supervision is provided solely by the family physicians. The public health nurses do, however, make home visits for prenatal instruction when cases are found or on the request of physicians.¹ The extent, if any, of people in the lower income group who receive little or no prenatal supervision is unknown. The Victorian Order of Nurses also visits homes but does not hold any prenatal classes.

In 1962, there were 1,015 resident live births and 838 non-resident live births.

POST-NATAL PROGRAM

The public health nurses make routine home visits as soon as possible after receiving the birth notices.² Thereafter, they visit if requested by the family physician or where the mother and child are not under regular supervision. Every effort is made to encourage mothers to have a post-natal checkup six weeks following delivery. At one time the public health nurses visited all obstetric patients at St. Joseph's Hospital. This saved much time since it permitted selective home visits only to be made. An attempt to have this programme in the Civic Hospital was turned down by the medical staff. Subsequently the medical staff asked for it to be withdrawn from St. Joseph's Hospital. It is felt that this was due to misunderstanding of the service and there is hope of restoring it.

Some maternity patients are referred by their doctors to the Victorian Order of Nurses, but the Health Department is unaware of these referrals. Thus, in spite of good liaison double visits sometimes occur.

WELL-BABY AND CHILD HEALTH CLINICS

Well-baby and Child Health Clinics are held once a month at six centres. As well as advice to the mothers about the normal growth and development of their children, initial immunizations and reinforcing doses are provided.³ There is a physician⁴ in attendance for the immunizations and for examination where indicated. Attendance at these conferences has been declining in recent years and less than one-half of eligible infants are believed to be brought.⁵ It is felt that this is because more people are going to family doctors, since they have insurance. However, the department staff feels that these conferences should not be entirely abandoned since there would otherwise be some people who might not receive supervision. Few children older than one year are brought to the clinics except for immunization.

¹Prenatal visits were made to 111 cases by the public health nurses and 7 by the V.O.N. in 1962. Based on 1,015 resident live births, about 12 per cent of eligible mothers were visited. (Method used by G. K. Martin and K. B. Ladd, "Maternal and Child Health Services, Ontario, 1958", *Canadian Journal of Public Health*, March, 1961, p. 112. The errors in this calculation are described in the article).

²*Ibid.*, p. 114. Birth registration visits under one month of age were made to 664 cases by the public health nurses and 17 by the V.O.N. This represents about 67 per cent of eligible cases. About 80 per cent of infants received at least one visit.

³See p. 177.

⁴Retained by the Board of Health on a part-time basis.

⁵328 individual infants were brought in 1962.

INFANT BOARDING HOMES AND BOARDING HOMES FOR MOTHERS

In Ontario the Maternity Boarding Homes Act requires that anyone boarding a child under the age of three years for money must obtain permission from the Medical Officer of Health. The public health nurses visit these homes and obtain the pertinent information before licenses are granted. These are inspected three to four times yearly. The homes are also checked by the sanitary inspectors to be sure that they meet sanitary requirements when they first apply for a licence. The homes are referred to the Department by the Children's Aid Society who supervises their child-care standards.

PRE-SCHOOL CHILD HEALTH PROGRAMME

The Well-baby and Child Health Clinics are available to older pre-school children but few of these actually attend following the age of one year.¹ The public health nurses visit homes as requested by doctors or families or as they themselves learn of problems.

At the time of the pre-school spring roundup, letters are sent to the parents requesting them to arrange a physical examination by their own doctor² for any child who will be starting school in the succeeding autumn. The parents are also urged to arrange a dental checkup. If this has not been carried out, the child is examined by the nurses on entering school. Where indicated, he is referred to the Medical Officer of Health for examination.

The packet sent out to the parents includes a letter, a health inventory form, a physical examination form, and a dental card and certain pertinent literature. Particularly important in the pre-school examination is the detection of defects so that the public health nurses may follow their progress to try to assure that they are corrected.

*School Health Service*³

School sanitation and food facilities are checked regularly as required by law. Other services are based on agreement between the health and education authorities.

PRIMARY SCHOOL SERVICE

In 1962-1963 only, immunization is to be carried out in Grade I through initial doses and smallpox vaccinations, as well as booster doses. In subsequent years, it is planned to restrict the programme to the pre-school period. Boosters with triad vaccine will be given in Grade III and in Grade VII, and a smallpox re-vaccination in Grade VII.

As to screening procedures, the Heaf test is to be performed in Grades I and VIII. Those with positive Heaf tests are rechecked by a Mantoux. There is a follow-up chest film if indicated. At present audiometric work in the public school system is carried out on Grades I, III and V by a Board of Education

¹See above p. 181.

²In 1962, 83 per cent of pre-school examinations were done by family physicians. Only 35 per cent returned signed dental cards.

³In 1962 there were 15 public elementary schools with 7,125 pupils, nine separate elementary schools with 2,622 pupils, three public secondary and technical schools with 3,642 pupils, and two separate secondary schools (one intermediate and one high) with 802 pupils.

technician. She also does the vision testing on Grades I, IV and VII. There is no audiometric testing in the separate schools. Vision screening is done by the public health nurses in the separate schools in Grades I, IV and VII using the Snellen chart and near-vision test with referral to parents and the family doctors if indicated. There is no school dental programme.

All children who have not had a pre-school medical examination are checked by the public health nurse with referral to the Medical Officer of Health if indicated. They are particularly interested in detecting remedial defects and referring these to parents for care. Subsequently children are seen only on referral by the teacher, principal, or parent to the public health nurse. Teacher—nurse conferences are held annually at which each pupil in a class is briefly discussed by the class teacher and the public health nurse. In Grade VIII a general classroom health talk is given and an individual counselling conference with the public health nurse is offered to each pupil.

An increasing amount of nursing time in the schools is being spent on counselling children referred for minor emotional, behaviour, and absenteeism problems. More serious cases are referred to the parents with the suggestion that the child be seen by the family doctor and, if indicated, by the community Mental Health Clinic.¹ Monthly conferences of the staff concerned with each case are held by the Mental Health Clinic, the schools, and the Health Department. Also a meeting on mental health in school children in each public elementary school is held annually with Mental Health Clinic representatives, the Medical Officer of Health, the Public Health Nursing Supervisor, the local school public health nurse, the local school inspector, the Superintendent of Schools, the local school principal, the local school guidance teacher, and the teachers concerned.

At the beginning of the school year in 1963, in attendance at a general staff meeting in each school, the Medical Officer of Health, the Public Health Nursing Supervisor, and the school public health nurse will outline the school health programme for the year.

There are opportunity classes for children of lesser capacity and limited facilities for physically handicapped children. Provincial and municipal grants are now available to assist the School for Retarded Children begun by a voluntary association of parents to meet the needs of these children excluded from the regular school system.

SECONDARY SCHOOL SERVICE

Tetanus toxoid and poliomyelitis (Salk) vaccine boosters are given in Grade XI. As to screening procedures, the Heaf test, (repeat Mantoux on positives), and follow-up chest film as indicated are carried out in Grades X and XII. No vision and hearing testing are being done at the moment. There is no school dental programme. Those who have not had a pre-high school physical examination by family doctors² after a letter and forms have been sent out are appraised by the public health nurse. Referral is made to the Medical Officer of Health if indicated. Any defects found are referred to family physicians through the parents.

¹See p. 193.

²In 1962, 68.5 per cent of pre-high school examinations were done by family doctors. Only 39 per cent of signed dental cards were returned.

It is intended to encourage teacher—nurse conferences, particularly between the public health nurse and the physical education and guidance teachers. Increased nurse health counselling is also being planned.¹ As well, a meeting of the public health nurses, supervisors, and Medical Officer of Health is held with the teachers at the beginning of each year.

The present high school programme is fairly limited with anywhere from one half-day to two-half days a week in the secondary schools. This policy of having the pre-high school examination by the family doctor is well accepted. For those in competitive sports, a yearly examination is required by the School Boards themselves. This is done by the family doctors.

GENERAL COMMENT

Peterborough is one of the communities which at one time had a school health service operated by the Public School Board. This was subsequently replaced by the present programme based on a general agreement with the Board of Health.² However, a number of questions have not yet been settled. For example, the school authorities possibly would like to have a full-time first-aid service, including attendance at athletic events, whereas the Health Department feels that this would not be making the most effective use of public health nursing time. The Department points out that, with training, teachers could do minor first aid. If more serious problems occur, medical or hospital care are required rather than nursing attention.

Another unsettled question is that of a school dental service. The Public School Board previously employed a dentist to carry out a survey and to provide treatment for children from needy families. Others were referred for care. This was discontinued under the new agreement with the Board of Health, partly because the former incumbent had retired and partly because of uncertainty as to the kind of programme there should be.

Presently, the pre-school and pre-high school letters to parents recommend a dental examination. The schools would like to have the detection and education service reinstated.

It has been suggested that any treatment of children whose families cannot afford to provide it be covered by a City grant, so they could go to the dentist of their choice rather than by employing a special school dentist. On the other hand several dentists pointed out that the older dentists already had all the work they could manage but that the more recently arrived dentists might welcome such work, initially at least. However, this would depend on a continuing influx of new dentists. This might not work out since it was pointed out that it has at times been difficult to find dentists willing to look after children covered for care under the provincial Mothers' and Dependent Children's Allowance. The Children's Aid Society have so far been able to arrange dental care for their wards. However, since the General Welfare Assistance Act only assists municipalities in paying for emergency extraction care, children of parents on public assistance, both of pre-school and school age, can only get preventive care through private arrangements made with dentists for free care or through payment by interested service clubs.

¹In 1962, 1,541 conferences were held with students.

²The audiometric programme remains under the Public School Board. It is proposed either to place this under the school health programme and to extend it to the separate and secondary schools or to integrate it more closely with Health Department Services.

There are some difficulties, chiefly of liaison and clarification of functions concerning mental health work. The view was expressed that the public health nurses should only be expected to handle straightforward emotional and personal problems. The guidance teachers tend to restrict themselves to vocational counselling and to selecting children for the opportunity classes. On the other hand, the Mental Health Clinic¹ feel that its case-load is such that only serious problems should be referred. The interpretation of what constitutes a serious problem tends to vary between the school and school service and the clinic. Some doctors also feel that the schools may stress the need for care to an extent where parents refer children to the clinic for matters which the family doctor could look after.

Another matter of concern to the schools and Health Department staff is that of sex education at the senior elementary and junior high school level. It is felt that some type of programme is needed since a number of pregnancies have occurred in children of these age groups.

Public Health Education

This is largely done through personal contact by the Health Department staff. Mass media are used when some special programme is being carried out, such as that for the Sabin vaccine. The Medical Officer of Health writes a weekly column in the Peterborough Examiner. Members of the staff also speak at various organization and club meetings on request.

Accident Control

There is no specific programme by the Health Department other than by the nurses noting problems during home visits. More recently, Poison Control Centre² follow-ups have been referred to the Health Department but these have been relatively few in number. The police have an active traffic accident control programme in the schools and with community groups.

Public Health Nursing and Home Care

Because there is a Victorian Order of Nurses branch³ in the City, the public health nurses do no bedside nursing care. The maternal and child health visits have been mentioned previously. There are an increasing number of home visits in connection with mental health problems. Cases are found in schools, among those discharged from mental hospitals, and among those attending the Mental Health Clinic. It is felt that this will be a growing activity. As well, there are the visits previously mentioned for tuberculosis and venereal disease control purposes. There appears to be some duplication of effort in the care of the aged and in prenatal and post-natal visiting between the Victorian Order of Nurses and the Health Department, in spite of good co-operation between them.

For home visiting, the City is divided into ten geographical nursing districts. Each nurse also serves a school or schools which may or may not all be in her district.

¹See also p. 193.

²See p. 190.

³See pp. 202-203.

Emergency Measures Organization

The Medical Officer of Health is the Medical Director for the City but because of uncertainty about the programme in the senior levels of government the programme has been hampered. There is an active Co-ordinator in the City.

Nursing Home Inspection

There are five nursing homes in the City. All are licensed and are considered to be adequately operated. These are checked routinely every two months by the sanitary inspectors and every three months by the public health nurses, unless they are visiting a patient for some other reason.

Liaison with Other Community Health Services

The Medical Officer of Health is a member of the boards of the Victorian Order of Nurses, the Children's Aid Society, the Peterborough County Tuberculosis Association, and the local unit of the Canadian Cancer Society. There are also close relations with the Welfare Administrator and the Regional Laboratory of the Ontario Department of Health, both located in the same building as the Health Department.

The Medical Officer of Health is a member of the Peterborough County Medical Society and is personally well accepted by his colleagues. There are, however, some areas of friction, especially in personal Public Health Department services because the City has a large number of doctors and competition is keen. The Medical Officer of Health is on the associate staff of both hospitals and attends the general staff meetings. He is a member of the general practice section in both hospitals and of the Infections Committee at St. Joseph's Hospital.

General Comments

Among the problems mentioned by individual members of the Health Department staff was an overlapping in services provided by different groups, for example, material help. A central registry, possibly in the Department, was suggested as a solution. The medical, housing, and recreational needs of the elderly and of younger handicapped people were felt to be only partly met at present. Problems also arise in coping with the dental, nutritional, and other health-related needs of families on general public assistance, and of low-income families of large size. Homemakers for lower income families are not available on any organized basis at present.

PHYSICIANS

General

Peterborough has an abundance of doctors and a heavy proportion do specialist practice. Moreover, it is one of the early areas in which group practice has been developed and there are now three well-established medical groups in the area, as well as a group of anaesthetists.¹ There are 78 doctors² in Peterborough, including the Medical Officer of Health, three pathologists,³ and the Director of the Mental Health Clinic. Sixty of the 78 doctors do specialist work and

¹The Peterborough Clinic has 17 doctors; the Medical Centre group has 17 members; the Scott Clinic has four members; the Anaesthesia Associates group has five members.

²As of September 1962.

³Two at the Civic Hospital and one at St. Joseph's Hospital.

18 do only general practice, a practising specialty proportion of just over 75 per cent.¹ As a result, a number of the internists, paediatricians, obstetricians, and surgeons do some general practice in addition to their specialty work. The specialties covered range through most types of surgery, obstetrics and gynaecology, psychiatry, dermatology, internal medicine, ophthalmology, otorhinolaryngology, radiology, plastic surgery, anaesthesia, paediatrics, public health, and pathology. Thus, most types of specialized work can be done in Peterborough. The surrounding country area has a further 12-15 doctors doing chiefly general practice.

Cases requiring long-term psychiatric care are not cared for in the Peterborough hospitals but are referred to the mental hospitals in Kingston and Whitby. Short-term psychiatric care is given in the Civic Hospital. Tuberculosis cases are referred to the sanatoria at Weston (Toronto) or Kingston. There is a chronic wing in the Civic Hospital so that chronically ill people can be cared for in Peterborough. There is no neurosurgeon or cardiac surgeon, and cases needing care are referred to Toronto or Kingston. Cancer cases requiring radiotherapy are referred to the Princess Margaret Hospital in Toronto. A doctor from the Princess Margaret Hospital holds a clinic twice a month at the Civic Hospital for diagnostic referrals from local doctors and for follow up of discharged cases.

Children on the register of the Ontario Society for Crippled Children are visited by the Society's district nurse. Much of the remedial surgical work is done in Peterborough. Other cases are referred to Toronto. Adults requiring extensive orthopaedic rehabilitation are referred to the new rehabilitation centre of the Rehabilitation Foundation for Poliomyelitis and the Orthopaedically Disabled. The Canadian Arthritis and Rheumatism Society has a visiting physiotherapist in Peterborough and there are hospital physiotherapy departments. Some consideration is being given to establishing a rehabilitation centre in Peterborough in association with one of the hospitals.

Comments

The problems in this area are not those of insufficient qualified personnel, though several people spoke of difficulty in finding a general family doctor. The competition in some fields is quite intense and this has led in the past to some friction with the Public Health Department. In general, however, relations with the Health Department are good and most of the doctors appear to welcome the programmes, though they wish to see only limited personal health services provided.

DENTISTS

There are 30 dentists in the area.² One of these is working in the Peterborough Clinic. The rest are working singly. One of the dentists is an orthodontist. The dentists are a well-organized group. They carried out an intensive effort to have a fluoridation vote carried in 1962 but the plebiscite was defeated. The dentists co-operate well with the Health Department, although, since there is no school dental programme, relationships are fairly limited.

¹Either fellowship and certificated specialists of the Royal College of Physicians and Surgeons of Canada, specialists with non-Canadian qualifications, or practising specialists with experience but no formal qualifications. A large majority are formally qualified.

²As of September 1962.

OTHER PROFESSIONAL AND TECHNICAL PERSONNEL

Registered nurses for hospital nursing are in somewhat short supply, particularly during the summer season when many wish to take holidays. During the winter the problem is not acute.¹ Many of the nurses are married women. Quite a number of the nurses are graduates of the Nursing Schools at the Civic Hospital and at St. Joseph's Hospital. Although there is no course in Peterborough, registered nursing assistants are also fairly readily obtained.

There are some shortages from time to time of other qualified personnel, such as physiotherapists, occupational therapists, medical social workers, dietitians, and laboratory and X-ray technicians, but the shortages tend to be temporary only. This is an area in which living conditions are pleasant. Professional people are attracted either to work themselves or because their husbands have come to work in business and industry which offer many jobs for skilled professional and technical personnel who, in turn, often have wives or other family members with training in health fields.

HOSPITALS

There are two hospitals in Peterborough, the Civic Hospital and St. Joseph's Hospital.

Peterborough Civic Hospital

This is a municipally owned, public general hospital with 380 beds and 52 bassinets.² The average occupancy rate is 85 per cent. The hospital board is composed of 16 members, 14 of whom are elected municipal or county council representatives and the other two of whom are the president and vice-president of the medical staff organization. The hospital administrator and two of his senior associates are graduates of the University of Toronto's School of Hygiene in hospital administration. The hospital also has an intern from this course for field experience each year. The hospital is accredited by the Canadian Council on Hospital Accreditation. The non-medical full-time staff number 509 and are divided as follows:³

registered nurses ⁴	144
registered nursing assistants	56
other auxiliary nursing personnel ⁵	61
physiotherapists	2
occupational therapists	1
medical social workers ⁶	2
dietitians ⁷	2

¹It is interesting that the private duty nursing registry in Peterborough has closed because of insufficient requests for private duty nurses. This occurrence may be partly a result of the hospital intensive care units.

²Beds set up as of September 1962. Rated capacity 380 beds and 52 bassinets in 1962.

³As of February 1963.

⁴Eight in the nursing school.

⁵Non-registered nursing assistants, nurses aides, and ward clerks.

⁶Not university school of social work graduates.

⁷Qualified dietitians.

medical records librarians ¹	2
registered X-ray technicians	3
non-registered X-ray technicians	3
registered laboratory technicians	4
others ²	232

The medical staff includes all of the practising doctors in the City and immediate surrounding area and has 85 active and 13 associate members. The Medical Officer of Health is a member of the general practice section of the staff. There is an active staff organization and there are a number of active staff committees, for example, a Tissue Committee, an Admissions and Discharge Committee, and a Medical Records Committee, as well as separate service groups. There is good general self-supervision by the medical staff of any work done in the hospital.

The hospital is of modern construction³ and is well equipped with operating room, emergency X-ray, laboratory, and other facilities. The beds are divided into sections, each headed by a specialist member of the medical staff, for medicine, surgery, obstetrics and gynaecology, psychiatry, paediatrics, and chronic care. There is also an intensive care unit for seriously ill patients. No neurosurgery or cardiac surgery are done at present and more complex orthopaedic problems are also referred, chiefly to Toronto, but also to some extent to Kingston. Long-term mental treatment cases are referred to the Ontario Hospitals in Kingston and Whitby, since only short-term psychiatric care is provided. Active tuberculosis cases are referred to the sanatoria at Weston (Toronto) and Kingston.⁴

Cancer diagnosis and surgery is performed but all patients requiring radiotherapy are referred to the Princess Margaret Hospital in Toronto. A cancer clinic, to which doctors come from the Princess Margaret Hospital, is held twice a month for follow-up examinations on patients who have been treated at that hospital in Toronto. They do no diagnostic referral work. Appointments are made by the Civic Hospital admitting office, and nurses and facilities for the clinic are also provided. Volunteers from the local branch of the Canadian Cancer Society⁵ assist in operating the clinic. Approximately 30 to 40 people attend each clinic.

The well-equipped laboratory is supervised by two pathologists who also do private work for doctors on patients outside the hospital. There is some overlap with the services of the branch laboratory of the Ontario Department of Health in Peterborough.⁶ The pathologists expressed some concern that they must charge for certain services provided, whereas the branch laboratory provides these free.

The X-ray facilities are modern and are supervised by the radiologists on the medical staff. The relationship of this service to the local Health Department has been described previously. All employees have an annual chest X-ray.⁷ There is a medical records department with a qualified medical librarian,

¹Registered.

²Stenographers, clerks, housekeeping, laundry, dietary, engineering, etc., employees.

³Built in 1949-50 and a new wing opened in 1961. Provision has been made for further extension when necessary. The original hospital, opened in 1885, has been entirely replaced.

⁴See p. 176, for relation to tuberculosis services of Municipal Health Department.

⁵See p. 211.

⁶See p. 194.

⁷See p. 176.

and the modern kitchen and dining facilities are supervised by a university graduate in household economics. There is a social service department.¹ A Poison Control Centre operates at the hospital.

There is a well-equipped general physiotherapy and occupational therapy department with two full-time physiotherapists and one occupational therapist. The work is supervised by a surgeon who oversees any programmes recommended by attending physicians. Physiotherapy is provided chiefly for selected medical, surgical, and chronic-care patients and for the occasional obstetrical patient. Occupational therapy is provided chiefly for psychiatric and chronic-care patients. No out-patient physiotherapy can be given except for follow up on discharged patients. Patients needing such care have to seek it either from the one or two private physiotherapists or the visiting physiotherapist of the Canadian Arthritis and Rheumatism Society.² The Y.M.C.A. pool is also available to a limited extent for physiotherapy purposes. The hospital would like to extend services to more in-patients and to out-patients but cannot do so at present for staff reasons. The possible establishment of an area rehabilitation centre, related to the hospital, is being considered.

There is a short-term hospital in-patient psychiatric unit of 26 beds, administratively totally separate from the mental health clinic.³ Its director is only employed half-time and is supported by a National Health Grant. The remainder of his time is spent on private office practice. The other staff include a psychologist, two social workers,⁴ and nurses. There is a waiting list for the in-patient section and it was felt that an additional full-time psychiatrist was needed, though other staff were in sufficient numbers provided that closer liaison with the clinic could be established. No fees are charged to patients in the unit and all care is by the unit staff. There are also private psychiatric patients admitted to the hospital under the care of either of the part-time private psychiatrists or a qualified specialist in internal medicine who has had extensive psychiatric training.

The hospital has a nursing school with approximately 110 students in a three-year course and 30 to 35 graduates each year. These nurses form an important part of the hospital nursing service. The nursing school is affiliated with the Hospital for Sick Children in Toronto and the Ontario Hospital in Whitby so that the student nurses spend time at each on paediatric and psychiatric nursing training. There is a health service for student nurses, staffed by a nurse.

The hospital has an approved course for registered laboratory technologists. Approximately three graduate yearly. It is in charge of the chief hospital pathologist. The hospital would like to have a similar course for X-ray technicians. Such a course would help in the obtaining of technicians for the hospital.

Relations with the City Health Department are cordial but limited. Pregnant mothers attending the Health Department prenatal classes tour the obstetrical floor of the hospital as part of the course. The Sabin vaccine programme was carried out for the hospital staff. Advice is sought as required on food handling and any related infection problems. The public health nurses do not visit obstetrical or other patients in the hospital at present.⁵

¹At the time of the visit the head had a Master of Social Work degree. She subsequently resigned and there were two non-university social workers in February 1963.

²See p. 204.

³See p. 193.

⁴Not university qualified.

⁵See pp. 180-181.

The waiting list for the chronic care wing averages three to four patients at any one time. There are some difficulties in getting sufficient nursing and ancillary personnel to staff the chronic care unit during summer vacation periods.

There is some difficulty in getting interns. The primary difficulty is that sufficient numbers of Canadian interns are not available to fill the demands of the hospitals. Were it not for overseas doctors taking an internship before writing the Medical Council of Canada examinations, interns would for practical purposes be unavailable.

The hospital staff feel that a hospital-based home care programme for the two hospitals would be helpful in relieving hospital bed pressures provided that some financial arrangement could be established. People would only use such services if there was no financial penalty. Otherwise the pressures to enter and remain in the hospital would continue.

St. Joseph's Hospital

This is a public general hospital operated and owned by the Roman Catholic Sisters of St. Joseph of Peterborough. The Governing Board consists of the Mother General and a Council. The Administrator and management operate the hospital. The Administrator has taken a course in Hospital Administration provided through the Canadian Hospital Association. The hospital is accredited by the Canadian Council on Hospital Accreditation. There is also a lay Advisory Board which advises the Governing Board on financial and business matters. This Advisory Board is composed of 16 business men, with representation from the City and County Councils, lawyers, bankers, and other business men from the community.

The hospital has 167 beds and 30 bassinets.¹ A new wing just being completed will raise the total to 240 beds and 41 bassinets.

The non-medical, full-time staff number 320 and are divided as follows:²

registered nurses	75
registered nursing assistants	30
other auxiliary nursing personnel	50
physiotherapist	1
laboratory technicians ³	6
X-ray technicians ³	5
others ⁴	149
medical records librarians ⁵	2
dietitians ⁶	2

The medical staff includes all the practising doctors in the City and the immediate surrounding area.

¹Rated bed capacity in 1962.

²As of February 1963.

³Not all are registered.

⁴Housekeeping, laundry, dietary and maintenance personnel.

⁵Registered.

⁶Qualified.

The Medical Officer of Health is a member of the general practice section and the Infections Committee of the staff. There is a staff organization and there are a number of active staff committees including specific service committees and the Medical and Surgical Advisory Committee, the Admitting and Discharge Committee, the Infections Committee, the Tissue Committee, the Nursing Committee, the Joint Conference Committee, the Emergency Measures Organization, the Pharmacy Committee, and the Medical Records and Trauma Committee.

The north wing of the hospital was built in 1889 and is to be replaced by the new section now being completed. There is also a newer section built in 1950. The hospital is well equipped with operating room, emergency, X-ray, laboratory, physiotherapy and other facilities. These services will be in the new wing. The beds are divided into sections, medicine, surgery, obstetrics and gynaecology, paediatrics, and isolation. Each is headed by a specialist member of the medical staff. As in the case of the Civic Hospital referrals are made for certain complex problems in surgery, in tuberculosis, for cancer radiotherapy, and for psychiatric care. The bi-monthly chest clinics operated in conjunction with the Ontario Department of Health and the City Health Department have been discussed previously.¹

The laboratory is well equipped but more limited than at the Civic Hospital. It is supervised by a pathologist member of the medical staff.² The hospital has a full-time physiotherapist who is supervised by one of the members of the medical staff. The modern X-ray facilities are supervised by a staff radiologist. The relations of this section with the municipal Health Department have been described.³

The hospital has a school of nursing with 99 students in a three-year course and about 30 graduates per year. These nurses form an important part of the hospital nursing service. Through affiliation arrangements the students receive training in the Hospital for Sick Children in Toronto for paediatrics, and the Ontario Hospital in Kingston for psychiatry.

The hospital has an approved course for registered laboratory technologists under the supervision of the staff pathologist. The hospital also has a course, supervised by the radiological staff, for registered X-ray technicians. There has been no difficulty in obtaining students for the X-ray technicians course, but very few take the course in laboratory technology.

Relations with the Municipal Health Department are limited but cordial. The public health nurses no longer routinely visit all mothers with newborn babies, though the hospital administration would like to have this service.⁴ The administrator indicated that a greater understanding of the ways in which the Department staff could assist the hospital would be helpful.

The hospital has adjacent to it a newly opened home for ambulant elderly people, Marycrest, which is operated by the same religious order.⁵ However, a problem exists for chronically ill, older bed patients. The hospital has difficulty in finding sufficient chronic hospital and nursing home facilities. The problem is

¹See p. 176.

²This department is soon to be placed in the new wing and will then have extensive facilities.

³See p. 176.

⁴See pp. 180-181.

⁵See p. 200.

further complicated since only the indigent have the cost of nursing home care covered through the City Department of Welfare. All others must pay directly for nursing home and selected care.

It was felt that a home care programme would only meet part of the need, since most difficulties occur with those needing either chronic hospital or nursing home care.

PETERBOROUGH MENTAL HEALTH CLINIC

The Mental Health Clinic, started in June 1953, has been financed primarily through the National Health Grants Programme. It is located in the Peterborough Civic Hospital in space originally designed for an out-patient clinic. The Mental Health Branch of the Ontario Department of Health operates the clinic and provides the staff, drugs, and equipment, and the hospital provides free the space and maintenance services. No fees are charged to patients. The staff¹ consist of the director² and one other half-time psychiatrist,³ two psychologists, one psychiatric social worker, one social work assistant—public health nurse, and clerical workers. A broad range of diagnostic and out-patient treatment services are provided for approximately 150,000 people in the surrounding county, for Victoria and Haliburton counties, and for the northern sections of the counties of Durham and Hastings. Clinics in Cobourg and Belleville serve the southern sections of these counties. There is also a clinic at the Ontario Hospital in Whitby.

Patients are accepted only on referral either from a physician or from a recognized organization, such as the Children's Aid Society, the courts, and the municipal Health Department. Approximately 75 per cent of the referrals are from sources in the City.⁴ The remainder come from areas outside the City. The year's patient load in 1962 consisted of approximately 169 cases carried over from 1961, 265 new cases, and 81 readmissions. At any one time about 175 cases are on the active list. On completion of its work with a patient, the clinic refers him back to the doctor or agency which made the original referral. Whenever a patient has a family doctor, whether the initial referral was done through him or not, it is the policy to keep him informed by reports of all that has been done for the patient.

Until about 1959, about one-third of the case load consisted of children under 16 years of age. Since then the pattern has changed so that at present about one-half of the referrals are children. The director estimated that three to five times the amount of staff-use and staff-time was required for a child patient as compared with an adult patient. In almost every instance for a child, interviews and work with parents, teachers, other relatives, etc., are involved. This has placed an added pressure on the existing staff and has created a need particularly for additional psychiatric social workers. It is felt that the August

¹As of August 1962. As of February 1963, the staff was short one psychologist and the psychiatric social worker.

²From 1953-1958 there was only one psychiatrist and the work load of necessity had to be limited.

³Half-time in private work.

⁴1961 referrals were estimated as just over 80 per cent by doctors, 3-4 per cent by the Health Department, and the remainder from other sources.

1962 complement would be sufficient for the present clinic load¹ but difficulty in retaining this level of staff is being experienced.

Relations with the City Health Department are good. The public health nurses do some follow-up work on patients from the clinic and from the Ontario Hospitals. There is also close collaboration with the Board of Education in Peterborough, including case conferences held at least once yearly on each school, and monthly conferences with Senior Board staff.²

General Comments on Mental Health

A number of problems occur. One arises from separate administration of the Mental Health Clinic and the in-patient psychiatric unit. The staff of each is different and continuity of care is hampered. Patients admitted to the unit from the clinic come under the care of a different doctor and in some cases are completely "worked up" again. In spite of efforts to co-ordinate activities examples were given where the public health nurses in the schools, the clinic and the in-patient unit in turn did complete studies of child patients. The situation is further complicated in that the clinic director is the chief of the hospital's psychiatry staff but is not on the in-patient unit staff and has no private, in-patient admitting privileges. The in-patient psychiatric unit staff do no out-patient clinic work. Thus, the existing administrative patterns aggravate to some extent the difficulties which exist in obtaining sufficient personnel and in using them to maximum advantage.

Another problem is that only patients admitted to a bed in the in-patient unit are covered for the cost of care under the Ontario Hospital Insurance Plan. A day-care programme, which had 12 to 15 patients on the average, has largely been discontinued as a result, except for one or two self-paying patients. This in turn has created a waiting list for admission to beds. Yet it is known that many short-term psychiatric cases may be looked after on a day-care basis.

The Ontario Hospitals in Kingston and in Whitby are quite a long distance away. It is felt by the clinic director that a 60-100 bed longer term mental hospital is needed in Peterborough, preferably in close relationship to the Civil Hospital and the clinic.

Particular care problems are presented by alcoholics and senile patients. Officially such patients are not cared for in the hospital unit. Some semi-senile people are in the chronic care section and are looked after by the psychiatrists.

REGIONAL LABORATORY OF THE ONTARIO DEPARTMENT OF HEALTH³

This laboratory provides services for an area north from Oshawa and Trenton, including the counties of Peterborough, Victoria, Haliburton, Durham, and Northumberland, and part of Ontario County. Approximately 40 per cent of the work is sanitary bacteriology, 20 per cent chemistry, and 10 per cent serology. Service is provided to practising physicians, health departments and

¹On the other hand, it is felt that the in-patient unit is in need of additional psychiatric staff. See p. 190.

²See p. 183.

³Located in basement of Peterborough Municipal Building.

units, hospital laboratories, and to citizens for water testing. Advice and services are available on request; for example, hospital outbreaks of Ch. Welchii or staphylococcal infection. In Peterborough, the two hospitals have laboratories supervised by pathologists which do most of the in-hospital work, though tuberculosis, enteric bacteriology, mycology, and some special chemistry work are referred to the Regional Laboratory.

The laboratory is headed by a qualified laboratory chemist-bacteriologist and has a staff of trained laboratory technologists. Relations with the City Health Department and the hospitals of the City are generally good. Some problems are presented by laboratories in some of the small hospitals outside the City with staff who have had limited training and with inadequate equipment.

Some smaller hospitals provide their own courses for laboratory technicians. The laboratory director pointed out that standards are variable and adequate teaching staff are often unavailable. It was suggested that all training and refresher courses¹ should be carried on under the aegis of the Ontario Department of Health and that the hospital laboratories without qualified medical supervision should be visited regularly for supervisory purposes by the Regional Laboratory staff.

Other suggestions were for routine stool cultures on hospital food handlers to detect Salmonella carriers, routine throat swabs on all obstetric and operating room personnel in hospitals to detect carriers of hemolytic staphylococcal and streptococcal strains, and routine serology for syphilis on all patients admitted, on a similar basis to hospital admission chest films. It was also pointed out that associated laboratories in hospitals directed by hospital pathologists were useful in areas not readily served by regional laboratories. However, by their nature, the associated laboratories were apt to have little interest in sanitary bacteriology. Finally, a local liaison between hospitals and public health authorities was urged so that sanitary inspectors could routinely check kitchens, food preparation, refrigeration facilities, and air bacterial counts in hospitals, rather than on request only as at present. This would help reduce hospital outbreaks of staphylococcal and other infections and assist in controlling them if they occur.

OFFICIAL WELFARE PROGRAMMES

Regional Office, Ontario Department of Public Welfare

The Regional Office in Peterborough and sub-offices elsewhere serve the counties of Peterborough, Durham, Victoria, Haliburton and Ontario. The functions of the staff are to handle applications and to administer directly the categorical allowances provided jointly by the Dominion and the Province,² and by the Province alone.³ In carrying out these duties, the people and families concerned are studied and assisted financially and otherwise. The office also generally supervises the administration of general welfare assistance by the area municipalities. As well as direct applications, referrals of needy people are made by the Municipal Welfare Department, social agencies, the Municipal Health Department, service clubs and others. The case load is heavy⁴ and little case work is possible in depth.

¹See Chapter II, p. 44, for a discussion of courses and qualifications for medical laboratory technologists.

²Old Age Assistance, Disabled Persons' Allowance, and Blind Persons' Allowance.

³Mothers' and Dependent Children's Allowance.

⁴The staff member interviewed had 436 current cases. There are two other staff workers.

One of the problems which the staff faces is that of providing help, financial or material, in an emergency, such as when a pension cheque is stolen or lost or when a pensioner becomes ill. Most people seem to adjust to the pension levels, modest as these are, but they cannot make provision for emergencies. The staff have no funds for these purposes and must seek assistance for people from church groups and service clubs. The purchase of drugs presents a particular problem for those on pensions since the municipality assists only those on general welfare assistance in this regard.

Occasionally some difficulty is found in obtaining a doctor who will accept the Ontario Medical Welfare Plan card for a pensioner and, thus, provide general medical care. Surgery for these people is arranged individually with surgeons willing to provide free care. Dental care and dentures also are a problem and care must be sought either from dentists willing to provide it without charge or through service clubs willing to pay for it. Children under 16 years of age whose parent is receiving the Mothers' and Dependent Children's Allowance receive a dental card entitling them to have dental care paid for by the Province at established fees. At times difficulty has occurred in finding dentists willing to accept these cards, since the fees paid are below the usual charges made.

Other needs noted from time to time are for employment, housing, and homemaking service for middle-aged and older people. The City has not as yet decided to implement the provincial sharing legislation for home nursing and homemaking service for low-income families.

City of Peterborough Department of Welfare

The Welfare Administrator and his staff of four workers administer the provisions of the General Welfare Assistance Act which provides financial assistance to those below the statutory means test level of income for any reason¹ and who have been residents of Peterborough for one year or more.² The payments are graded according to size of family and the circumstances, as determined by investigation by the staff, and are the maximum basic amounts shared by the Province.³ All recipients of assistance receive an Ontario Medical Welfare Plan card for medical services and in addition emergency drugs prescribed by a doctor are provided by the Department. The cost of public assistance and of supplements up to \$20.00 per month in individual cases at the discretion of the Department is shared, 20 per cent by the municipality and 80 per cent by the higher levels of government.

The actual hospital costs of short-term indigents are paid by the municipality at the statutory rate of \$7.45 per day with the Ontario Hospital Services Commission paying the remainder. About 65 to 70 per cent of those receiving assistance are considered to be semi-permanent indigents and the municipality pays their hospital insurance premiums rather than any costs incurred.

The people and families receiving assistance are regularly checked. Unemployed but employable people must register with the local office of the National Employment Service and report at least every two weeks to see if suitable work

¹Waiting for Mothers' and Dependent Children's Allowance, other categorical allowances unable to work because of illness, unemployed but employable.

²Otherwise they are returned to their former municipality of residence.

³Maximum of \$180.00 plus emergency medicine for a family with six or more dependents and \$52.00 per month for a single person.

is available. One of the problems is that many of these people have limited education and no particular training. Some are suitable for vocational retraining under the Dominion-Provincial programme but unfortunately quite a number, for reasons of capacity, lack of education, or age, are not.

Dental care presents a problem since, other than for children under 16 years of age on the Mothers' and Dependent Children's Allowance, only emergency extractions are a shareable cost with the Province. The absence of a school dental programme adds to the problem of getting preventive or restorative care for these people.

Eye examinations are shared by the Province at the 80 per cent level if arranged by the City. Glasses are not provided. At present the City makes a direct grant to the Victorian Order of Nurses to cover home visits to indigent patients.¹ No homemaking service is provided for by the City. The City pays the difference between the provincial payment and the deduction from a patient's pension for registered nursing home care for indigents up to a level of \$5.00 per day.² The Administrator feels there is a need for more than the existing five registered nursing homes. The chronic care wing at the Civic Hospital does not meet this need fully since, once hospital treatment is of no further value, the Ontario Hospital Insurance Commission will no longer pay for hospitalization. Patients who are well enough are transferred to the municipal home for the aged or to a nursing home as vacancies are available.

The City pays a subsidy of up to \$2,000.00 per year to each of two private ambulance firms for providing ambulance service to those receiving allowances³ and to those on general welfare assistance.⁴ Funerals for indigents are subsidized at the rate of \$175.00.⁵

ACCOMMODATION AND OTHER FACILITIES FOR THE AGED

Fairhaven Home for the Aged

This home on a 17-acre treed site overlooking the Otonabee River is operated by the City and opened in 1960. It was designed originally for people 70 years of age or over without other financial resources than their Old Age Security Pensions. Its scope has been enlarged under the provincial Homes for the Aged Act to include people over 60 years who are unable to support or care for themselves, people over 60 years who are mildly senile but not mentally ill or defective, people over 60 years who require bed care and general nursing but not needing full hospital care, and those under 60 years in special circumstances where they cannot be cared for otherwise.⁶ These last people are admitted only with the sanction of the provincial Minister of Public Welfare.

¹\$7,400.00 per year in 1962.

²\$59.75 is deducted from the monthly pension of \$65.00. The Province pays an additional 80 per cent up to \$100.00 per month and the City makes up the remainder of the cost to a maximum of \$5.00 per day.

³\$5.00 per person.

⁴\$10.00 a day and \$12.00 for a night trip.

⁵Actual cost was reported as \$200.00.

⁶For example, younger adults with severely disabling conditions for whom other suitable arrangements cannot be made.

Admission is based on an application through the municipal Welfare Department and subsequent medical examinations by the applicant's family doctor and the Fairhaven physician. Seventy per cent of the maintenance costs are paid by the Province. People who are dependent on the Old Age Security Pension have all but \$9.50 per month of the \$65.00 total retained by the Home to assist with maintenance expenses. Those receiving allowances shared between the Province and the Dominion, such as the Disabled Persons' Allowance, have these discontinued unless they are able to pay something towards their maintenance out of other funds. Any personal needs are provided by the Home or families for the former group. Residents with sufficient financial resources are expected to pay part or full *per diem* maintenance, as established from time to time. Those with assets over \$1,000.00 must sign an agreement arranged by the City with the Victoria and Grey Trust Company who administer their assets. After six months, such people can be called on to pay their maintenance costs. In August 1962, approximately one-third of the residents were paying their own maintenance costs in full. About two-thirds were receiving care under other arrangements though over 90 per cent of these were contributing something through the pension deduction system.

Medical care may be obtained from one's own doctor or the Home physician. The Home doctor calls regularly twice a week and is otherwise on call. Calls authorized by the superintendent are paid for by the Home at a set rate. Coverage under the Medical Welfare Plan is discontinued. An admission chest X-ray and a physical examination by the Home doctor are paid for by the Province. An annual examination and chest X-ray is also provided. The Medical Officer of Health has suggested that an alternative to the annual chest film might be a sputum test. Those requiring acute hospitalization are readily transferred to the Civic Hospital.

One problem is with those who become chronically ill because of the backlog of patients waiting for admission to the hospital chronic-care wing. The hospital staff feel that some of these people could be cared for at Fairhaven, whereas the Home staff point out that they have not the qualified nursing staff to care for other than minor illness and routine bed care. Thus, they are reluctant to accept people with chronic illnesses requiring more extensive care. Because of this problem, some needing chronic care must be transferred to registered nursing homes. In these the provincial Department of Public Welfare pays up to \$5.00 per day for the care of those on public assistance or other means test allowances and in turn retains most of the allowances.

Those who die in hospital without means are buried under an agreement by the City and the local undertakers.¹ Those who die in Fairhaven without means are buried under an agreement between the Home and the local undertakers.²

The Home has room for 175 residents. As of the middle of August 1962, there were 96 residents. There is, therefore, ample space but there is still some social stigma of this being the "poor house" attached to the Home.³ This tends to restrain self-supporting elderly people, who might otherwise apply because they

¹\$175.00 per burial.

²\$175.00 per burial.

³The requirement of signing an agreement for the management of assets is a barrier to application by these people.

wish care, to refrain from doing so. However, approximately one-third of the residents are self-supporting, an indication that attitudes may be changing gradually.

Of the 96 residents, 74 were women. The women's special care (senile) section of 16 places was full whereas only 2 of the men's 12 special care places were filled. Ten men and 30 women were receiving full bed care. Ten men and 28 women were fully ambulant and free to come and go as they wished.¹ The average age of the residents is 78 years and most are in their eighties.

Most of the rooms are double rooms, a few are single rooms, and a few are four-bed rooms. There are also facilities for eight married couples. Residents may not bring large pieces of furniture but may bring small belongings, such as lamps, pictures, plants, etc. There are numerous balconies and there is a small patio for every three rooms. In design and decor the Home is modern, with up-to-date eating, washing and toilet facilities.

The special care sections have special gardens surrounded by a fence to prevent the people from wandering away. There are two lounges on each floor with planters, television, bird cages, etc. There is a small pleasant library with books, magazines, and newspapers. A modern attractive chapel is used for services arranged through the City ministerial association. Except in the bed-care section² relatives and friends may visit anytime. A tuck shop for snacks and small personal needs is open for two hours in the afternoon. Outside groups, such as the Salvation Army, church groups, service clubs, and the Women's Auxiliary of the Home visit regularly to chat, write letters, do shopping, provide entertainment, etc. Films are shown weekly. A craft shop has been started by the Women's Auxiliary but most of the participants are women. A garden for the men and carpentry have attracted little interest. Most of the men seem to prefer to sit, smoke, and play cards.

The staff, other than the superintendent, comprise about 50 in all, including four registered nurses, 26 registered nursing assistants and orderlies, and the remainder are kitchen and maintenance staff. Competent staff are sometimes difficult to obtain and retain. An annual chest film and examination is required. The municipal Health Department inspects the kitchen and sanitary facilities routinely.

Anson House

This attractive brick and stone home is located near Fairhaven on a landscaped five-acre plot. Anson House has been operated by the Protestant churches of Peterborough for over a century. The present daily charge is \$2.46 and the majority of residents pay the full amount. For the few residents entirely dependent on the Old Age Pension, \$55.00 is accepted as board and \$10.00 returned to the pensioners as pocket money. A provincial grant under the Charitable Institutions Act is given for 75 per cent of the difference between \$55.00 and the full cost. The Home is self-sustaining because of generous bequests, several of which were from former residents.

¹The City bus service stops at the gate every 20 minutes and at 2, 3, and 4 p.m. drives in to the door.

²2-4 p.m. and 7-9 p.m. daily.

All residents must be ambulant. There are 31 beds, all in single attractive rooms. As of February 1963, there were 11 men and 17 women residents. Residents are encouraged to bring some of their personal furniture to provide a homelike atmosphere.

Church services are held each Sunday. There are three or four entertainments each month by church groups, service clubs or private individuals. Also invitations to outside organizations and private homes. In summer, sightseeing drives are arranged by Board and Auxiliary members.

Marycrest

This is a modern home opened in 1959 and operated by the Sisters of St. Joseph of Peterborough. It has replaced the old House of Providence, opened in 1890, for the aged and infirm in the Diocese of Peterborough. It is located adjacent to St. Joseph's Hospital, which is operated by the same Order.¹ There are 144 beds, divided into 18 single rooms, 11 double rooms, 24 four-bed rooms, four married couples quarters, and 12 infirmary beds for minor illness care. People may bring personal belongings and furnishings within limits. Although the Home is for ambulant residents, those who become bedridden are kept unless they need to be in hospital.

As of September 1962, there were 94 residents. Most were Roman Catholics but people of any religion may apply. The Home operates under the Ontario Charitable Institutions Act. Maintenance services come from charges of \$80.00 per month for a four-bed room, \$95.00 per month for a semi-private room, and \$120.00 per month for a private room. Those dependent upon the Old Age Pension pay \$57.00 per month for a four-bed room. The Province, under the Charitable Institutions Act, makes up 75 per cent of the maintenance deficit up to a set amount. The remainder of the deficit is assumed by the Sisters.

The Home is modern in design and decor and has an attractive chapel and sitting rooms with television, radios, and plants. Spacious verandas open off the sitting rooms. There is a well-equipped kitchen and dining room. The Home has a modern ventilating and exhaust equipment. Capital grants of \$2,500.00 per bed were received from the Province. Other capital equipment funds were raised by private donations, diocesan funds, and a bond issue taken out by the Sisters.

The staff, other than the 11 sisters who provide the general supervision and nursing, is made up of 3 experienced nursing assistants, and 15 kitchen and maintenance help. Care in the design and construction of the building, such as terrazzo floors throughout and tiled walls in washrooms, has reduced the problems of maintenance to a minimum.

Kinsmen Garden Court Apartments

The idea was conceived in 1960 by the Peterborough Kinsmen's Club of building a number of bachelor and double apartments for older people with moderate incomes under the Canadian Government mortgage and housing regulations. The initial group consisting of 16 double and 14 single apartments in single story buildings were opened in 1961 and are located on a pleasant, landscaped 12-acre site convenient to public bus transportation. The land was donated by the City.

¹See p. 191.

The buildings have cement foundations and brick walls. The double apartments have a living room, modern kitchenette, bedroom and bathroom. The residents bring their own furnishings. The flats have hardwood or tile floors and large windows and are attractively decorated. Each apartment has a supplied refrigerator and stove, allotted use of the automatic washing machines and dryers supplied, central garbage room facilities, and storage space in a central storage room.

Applicants must be 60 years of age or more, have been residents of Peterborough for at least a year, and have a total income not exceeding \$147.00 per month for a single person and \$201.00 per month for a couple.¹ There were 90 applications initially for the 30 units to be constructed for a total of 46 residents.² In August 1962, there was a waiting list of approximately 50 people. In the first year of operation only one vacancy occurred. Approval by the Kinsmen's Club has been given for a further 20 units.

Residents pay a monthly rent of \$44.00 for a single unit and \$55.00 for a double unit. The rent covers operating administrative costs and 10 per cent is placed in a maintenance fund. Kinsmen Club volunteers carry out or arrange for any repairs. One of the tenants receives free rent in return for caretaking services. The tenants pay for their own electricity usage but the administration pays for water and provides heating from a central unit. The people are similar to any tenants and are free to come and go as they wish. No other services, such as nursing, are provided. Some have private cars though most use public transportation which comes to within a block of the apartments. Most have attractive gardens and lawns in front of their flats. Shuffle boards, benches and patios are provided in a central landscaped area. Mail and garbage collections are those of the municipality.

The Kinsmen's Club raised an initial \$30,000.00 cash and received a provincial capital grant of \$15,000.00. The remainder of the \$211,000.00 capital cost is being financed through a 45-year mortgage with the Central Mortgage and Housing Corporation. All administrative matters are handled through a special committee of Club members. Taxes were set on a pre-arranged basis with the City. This is a most attractive and valuable project. The apartments visited were comfortable and pleasant and the residents were delighted with the accommodation.

In 1962 the building project received the Canadian Design Award and the Club was presented with a citation by the Governor General.

Senior Citizens Clubs and Recreational Facilities

The first organized activity was the formation of the Golden Mile Club for older women under the aegis of the Soroptomist Club in 1947. This group has a current membership of about 70 and provides recreational activities and fellowship for its members on a fortnightly meeting basis at the Young Women's Christian Association. As of the end of June 1962, the Club became independent of the Soroptomist sponsorship.

¹A few residents are dependent on families to subsidize Old Age Security Pensions.

²Sixteen double and 14 single units.

In 1954, the Local Council of Women sponsored a Senior Citizens Club for men and women. Its present membership is approximately 150 and it meets monthly.

It became clear that a permanent centre offering daily facilities was also desirable and in 1958, under the sponsorship of service club representatives, the Local Council of Women, and other interested citizens, the Senior Citizens Association of Peterborough received a charter. Its purpose was to build a centre for senior citizens' activities. Some money was obtained from a capital fund drive in 1958. A campaign in 1961 supported by industry, private donations, and a door-to-door "blitz", raised the additional capital needed. The Centre was established in a renovated building and opened in October 1961.

It is open from 10 a.m. to 10 p.m. on weekdays and in the afternoon on Sundays. Activities include handicraft, art, music, choral groups, as well as games, reading, television, and parties. Facilities for making snacks are also available. The programme is operated for the older people and costs are met by funds raised through proceeds from teas, handicraft sales, and voluntary gifts etc. There are no formal membership fees. Some 450 to 500 people use it monthly.¹ If plans to enlarge the Centre materialize, there is some likelihood that the Golden Mile Club and Senior Citizens Club will use it for their meetings.

General Comments

A number of problems and suggestions were raised by those working with older people and by older people who were met. Some type of body to act as a referral and co-ordinating agency for the official and voluntary health and social welfare services available was suggested. Counselling services were felt to be badly needed on such matters as budgeting, and accommodation, etc. Friendly visiting, shopping, hot meals, and housekeeping services were also mentioned by a number of those interviewed as needs for those home-bound for health or transportation reasons.

There is also a need for more flats of the low-rental type for people of moderate incomes. In August 1962, the municipality conducted a survey to determine the need for a low-rental housing project, not solely for older people. It is planned to build this in co-operation with the Dominion and Province under Central Housing and Mortgage arrangements. More small residential homes with single rooms for older people of moderate income similar to Anson House would be helpful, since some people are reluctant to enter Fairhaven under the present admission requirements and shared-room basis.

Drugs for low-income elderly people, dentures, denture repairs, and glasses also present financial problems. The Kinsmen assist, on occasion, in providing eye examinations and glasses, and the Soroptomists supply needed drugs.

OTHER VOLUNTARY HEALTH AND SOCIAL SERVICES

Victorian Order of Nurses

Three staff nurses work from an office in the Civic Hospital and offer care to people in the City only. The services provided on a visiting basis are generalized

¹So far those in Fairhaven, Anson House, and Marycrest who are ambulant use the Centre to limited extent only. It is hoped more will use its facilities in the future.

bedside nursing in the home, health teaching to prenatal patients and to post-natal patients for the initial six weeks following delivery,¹ and general health teaching in the home. Prenatal patients are referred to the Health Department prenatal classes. All work is done on the referral of a doctor and under his instructions. The active case load in August 1962 was 49 people. There were 337 cases in total served in 1962 through 5,233 home visits. Of these visits, 92 per cent were to adults, 78.7 per cent were to Old Age Pensioners, 3 per cent were to maternity cases, 3 per cent were to school-age children, and 0.5 per cent were to pre-school children.

Fees are charged to patients on a sliding scale based on ability to pay. A municipal grant was received in 1962 to cover care for indigent and public assistance cases. The Victorian Order of Nurses also received an allocation from the Peterborough Red Cross and Community Fund Campaign in 1962. A local board is responsible for local fund raising. Some general supervision of the nurses is provided by the national Victorian Order of Nurses organization.

An abbreviated financial statement for 1962 shows:

The bank balance as of January 1962 was \$490.20.

<i>Revenue</i>	
City of Peterborough	\$ 7,400.00
Community Chest	7,800.00
Nurses' collections	5,129.98
Transfer from savings	2,000.00
Interest	567.55
Members, donations, sundry	92.00
	<hr/>
	\$22,989.53

<i>Expenditures</i>	
Salaries	\$14,956.21
Automobile expenses and depreciation	2,073.23
Victorian Order of Nurses retirement	466.17
Rent, light, cleaning	240.00
Equipment, office supplies and other operating expenses	1,775.76
Dues, convention expenses, V.O.N. Headquarters, annual outing	343.94
Transfer to savings	2,000.00
	<hr/>
	\$21,855.31

Allowing for cheques outstanding the bank balance at the end of 1962 was \$644.02.

Among the service needs noted by the nurses were homemaker service² and more home physiotherapy for stroke and other cases. The growing suburbs outside the City limits have no Victorian Order of Nurses service though most of the residents earn their living in Peterborough.

¹Thereafter families requiring visits are referred to the Health Department.

²Many of their patients cannot afford the private homemaking services now available.

The office was moved in 1962 to the hospital in an effort to develop a hospital referral programme and a closer liaison with the doctors. It is hoped that more doctors will use the services more fully and that better continuity of care of patients between hospital and the home will result. This move also encourages closer relations with the nursing staff of the hospital.

The view was also expressed that with the growing number of health and social service agencies in Peterborough some type of central referral registry might be useful.

Canadian Arthritis and Rheumatism Society

The Ontario Division of the Society has a physiotherapist in Peterborough to give visiting physiotherapy services in the home under a doctor's instruction. The Divisional Office provides social work consultation and case work on request. Service is offered to arthritic patients primarily but as time permits service is given to non-arthritic patients. The service is offered to a limited extent to people in the nearby county areas. By special arrangement certain services are sold outside Peterborough County. Once a week a treatment clinic is held at the Durham-Northumberland Health Unit Centre in Cobourg. Some home visits are made in Cobourg and Port Hope. One hundred and ten new cases were opened in 1962. Approximately one-half of the requests came from doctors and the remainder were self-referrals. In the latter instance, the written request of the family doctor must be received before any treatment is given. In a few cases patients have been rehabilitated enough to do some part-time or light work, but finding suitable employment has been difficult. Patients are encouraged to participate in a weekly swimming and hydrotherapy programme. A service club pays for the use of the Young Women's Christian Association pool; instructors donate their time and another service club transports patients free.

Relations with the hospitals, the Victorian Order of Nurses, the March of Dimes,¹ and the Ontario Society for Crippled Children are good. Contacts with the Health Department are cordial but more limited.

One of the problems noted was that of arthritics, especially older people, who were not referred for care as early as they might be for best results to be obtained. It was felt that only a limited homemaking service was needed but that help in obtaining mechanical home aids, such as raised toilet seats, etc. would be valuable. Physiotherapy among chronic care hospital and nursing home patients was felt to be limited in extent at present, because of the shortage of physiotherapists in Peterborough. The Society in co-operation with interested local doctors is studying the possibility of establishing a generalized rehabilitation centre in Peterborough. Patients may be sent to the University of Toronto Rheumatic Diseases Unit in Toronto.

A lay board administers the general activities of the branch, including fund raising and public education.

A local medical advisory board gives general supervision to the treatment programme in Peterborough, including professional educational work with the doctors. The professional staff of local branches is employed and paid by the Ontario Division office through funds raised by each branch. Other local

¹Rehabilitation Foundation for the Disabled.

expenses are also financed through the central office. An annual budget is agreed on between the Ontario office and the local branch, including allotments for the research programme and the central administration. All funds are raised locally. In the case of Peterborough, the 1962 revenue consisted mainly of a grant from the Peterborough Red Cross and Community Fund of \$6,200.00 and of a small amount from fees¹ collected from patients able to pay. A local women's association provides special aids and personal assistance to patients and helps to cover any deficit between revenues and budget expenditures by raising money through bazaars and related means. All branches are represented on the provincial lay board and medical advisory board through their respective chairmen.

Ontario Society for Crippled Children

The Peterborough District Office with two nurses² and a secretary provide services to orthopaedically handicapped children from birth up to 19 years of age in the counties of Peterborough, Durham, Northumberland, Haliburton, Ontario, and Victoria under the general direction of the Society's head office in Toronto.³ A patient is discharged from the active file when the condition is cured and there is no residual disability, on becoming 19 years of age,⁴ when he has left the Province, or when he has moved without a forwarding address. In 1962, there were 919 patients under supervision in the district, 243 of whom lived in Peterborough County. The nurses work closely with local associate service clubs who provide certain local services and sponsor local Easter Seal campaigns, with doctors, with health departments, and with others interested in crippled children's work. The nurses' services, local services of associate service clubs, and the province-wide services of the Society are available only on referral from a doctor. The nurses assess cases in relation to the services offered and provide general follow-up supervision. No bedside nursing care is given. The local associate service clubs provide equipment, such as appliances, braces, and wheel-chairs and cover the cost of physiotherapy, X-rays, transportation to treatment and rehabilitation centres, and camp holidays for needy children. Among the services directly provided through the head office are the district nurse programme, five summer camps, a central equipment loan cupboard, medical research, assistance to treatment and rehabilitation centres used by the Society throughout the Province, and diagnostic clinics in some distant outlying areas.

Revenues are obtained from the local Easter Seal campaigns.⁵ The Peterborough Rotary Club is the associate club in the City and surrounding area. Fifty per cent is retained by the local associate service clubs for local work and the other half is sent to the head office for use in maintaining the province-wide services which are available to crippled children from any part of Ontario.

¹Full home treatment fee—\$5.00; full treatment centre fee—\$3.50. Patients are asked to pay what they can afford.

²The Society's district nurses hold public health nursing certificates. A nurse must also have had at least two years of experience in generalized public health nursing and three months of intensive pre-service training in rehabilitation nursing. The 1962 Peterborough District Office costs were: salaries—\$13,875.00; office—\$1,434.00; travel and car maintenance—\$2,624.00.

³The district nurses are supervised by a Nursing Service Supervisor in the Toronto head office.

⁴With parental permission referral is then made to the Rehabilitation Foundation for the Disabled. See p. 206.

⁵The 1962 Easter Seal Campaign in the City and its surrounding area raised \$11,055.49.

The Ontario Crippled Children's Centre in Toronto which provides special ized diagnostic and rehabilitation services was planned and built by the Society with funds from a special appeal which was separate from the Easter Seal Campaign. However, it is operated and financed by its own board, which is distinct from that of the Ontario Society for Crippled Children. Easter Seal funds are used to supplement the financing of the Centre.

Variety Village in Toronto which provides vocational services to handicapped boys from 16 to 18 years of age is administered by the Society. But it is financed partly by the Variety Club which independently raises operating and maintenance funds and by grants from the Ontario Department of Public Welfare.

A few handicapped children would benefit from special school classroom facilities; a very few are also mentally retarded. The problem in a city, such as Peterborough, is that they do not number more than a handful. It is difficult to know what arrangements to make for educational and vocational training purposes. At present arrangements as indicated are made through regular educational and vocational institutions.

The Rehabilitation Foundation for the Disabled (March of Dimes)

The Foundation is concerned with the medical and economic rehabilitation of physically disabled adults, 19 years of age and over. Patients previously under the purview of the Ontario Society for Crippled Children are referred to the Foundation at this age. Peterborough is served by the Toronto District Office which covers the counties of York, Peel, Halton, Haliburton, Simcoe, Victoria and Peterborough, Ontario, Northumberland, Durham, and the District of Muskoka. Caseworkers provide service in each district office area under the direction of volunteer district medical advisors¹ and branch boards. These in turn are represented on the provincial Board of Directors and Medical Advisory Committee.

Any family doctor may refer a patient to the Foundation for clinical assessment and a rehabilitation programme as indicated. All patients referred are brought to one of the Foundation's clinics for evaluation and treatment by specialists in orthopaedics and physical medicine. Clinics are held at least weekly at the Toronto General, Toronto East General, Toronto Western, St. Joseph's, and St. Michael's hospitals in Toronto. The Foundation Psychological Services Centre in Toronto provides work assessment and a work conditioning programme at the assessment shop. There is no local Foundation rehabilitation centre in Peterborough but the physiotherapy and physical medicine services of the two hospitals are used on occasion as requested by the medical advisors. The nearest workshop is in Trenton and there are two in Toronto.² The Foundation also operates Operation Reliance Incorporated, a factory employing only disabled people, to do industrial machine shop work on a fully competitive basis and J.O.B. (Just On Break), a special job placement service for those who require more assistance than is available through existing community agencies, such as the special placement section of local offices of the National Employment Service. There is also close liaison with the Rehabilitation Officers of the Ontario Department of

¹Toronto district advisors from each of the hospitals listed in the second paragraph, as well as at the Hospital for Sick Children and Lyndhurst Lodge Hospital, supervise the work done.

²Patients produce jewellery which is marketed in regular retail outlets. A third Toronto workshop is to be opened soon.

Public Welfare. If a patient cannot meet the cost of treatment and rehabilitation, a caseworker endeavours to obtain support through government assistance programmes and service club sources. Only where existing sources of funds do not meet the needs are Foundation funds used. All money raised from the City of Peterborough and its immediate environs is sent to the District Office which dispenses all funds. Money is obtained in Peterborough through the annual March of Dimes Campaign only.¹ In 1962, there were 32 cases under the purview of the Foundation in Peterborough, of whom 19 received active assistance in the year.

Peterborough and District Association for Retarded Children

This is a local parent- and citizen-sponsored group which provides a school, Trafalgar School, for children with an I.Q. of 50 or less, where they receive training by qualified teachers as the pupils' capacities permit. In 1962 the school had 45 pupils. It serves the City and nearby county area. As well, a Sheltered Workshop was opened in 1961 for retarded youths over 18 years of age. It had 18 active participants in 1962. Monthly parent education meetings are also held. Social and small personal needs of pupils are also met as required. The programme is operated by a local board and committees.

The workshop has a separate budget from the school and other activities. Funds are received from a variety of sources as the following abbreviated operating statements indicate:

Abbreviated Operating Statement, 1962

Receipts	
Current bank account, January 1, 1962	\$ 1,387.93
Provincial grant	12,430.10
Peterborough Red Cross and Community Fund	3,629.00
Donations	693.80
Membership dues	133.00
Craftwork sales	111.50
Pupils' bus fares	182.50
Other sources	120.24
Withdrawal from savings	185.01
	<hr/>
	\$18,873.08
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Disbursements	
Salaries and wages	\$12,052.00
Maintenance, equipment and supplies	4,934.08
Part payment, new school bus	1,262.00
Ontario Association Retarded Children annual assessment and research	625.00
	<hr/>
	\$18,873.08
	<hr/>

¹In 1962—\$5,733.00. Expenditures for the City for services were \$6,918.00. The additional costs over revenue were covered by the equalization of revenues and expenditures for the entire Province by the provincial office.

Sheltered Workshop, 1962

Receipts

Bank balance, January 1, 1962	\$ 2,478.92
Peterborough Red Cross and Community Fund	2,500.00
Canadian General Electric rent	972.00
Donations	1,110.48
Contract earning and other sales	2,458.75
Tuition fees	763.00
Other	304.92
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	\$10,588.07

Disbursements

Salaries	\$ 4,423.06
Maintenance and supplies	4,240.65
Loan repayment	1,924.36
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	\$10,588.07

Catholic Social Service Bureau

Though started by the Roman Catholic Church and staffed by two qualified social workers, one of whom is a priest, the Bureau functions as a non-sectarian family-counselling agency and has a non-sectarian board. It is the only general family agency in the City. Clientele come from all groups and about half are not Roman Catholics. The services include marriage counselling, personal counselling, counselling on child and other internal family problems, and advice on budgeting, etc. The staff work closely with the Mental Health Clinic, the Health Department, the Children's Aid Society, the John Howard Society, and the Chronic Care Hutchison Wing staff in the Civic Hospital, as well as with the Municipal Welfare Department. No material assistance is given and there is no charge for services.

Among the problems currently providing difficulties are the relative lack of prompt residential care for alcoholics and drug addicts. The hospitals and Mental Health Clinic accept only acute delirium tremens cases. The waiting list for the government and private treatment clinics in Toronto is three to four weeks. Services for drug addicts are even more difficult to obtain.

Drug costs for welfare patients and low-income families present a problem. The Red Cross and some service clubs will assist but their policies tend to change because of their changing officers and voluntary nature. The Municipal Welfare Department has shown itself somewhat reluctant to pay for drugs on occasion.

Another problem is that of elderly people who need care but are reluctant to enter an institution. This is also of concern to the public health nurses. At present this is a difficult matter to resolve in most communities but it is made more so by the absence of an organized home care programme in Peterborough.

Dental care of a preventive or restorative kind for welfare and low-income families also presents financing problems. The municipal Welfare Department provides payment for emergency extractions only for those on public assistance. Service clubs provide some assistance and some dentists will give some care free or at reduced cost.

Pre-marital counselling services are also felt to be needed more extensively in Peterborough. The Bureau, for obvious reasons, largely works in this field with Roman Catholic church and other groups. The Health Department also pointed out a need for a programme of this type.

Some type of central health and social service referral body was suggested as being of value, possibly provided by the Health Department.

The full income in 1962 was from the Peterborough Red Cross and Community Fund.¹ Expenditures were for salaries,² clerical staff,³ and general office expenses.⁴

The Canadian National Institute for the Blind

General Statement of Programme in Ontario

The Canadian National Institute for the Blind is a private service organization, supported by public subscription and grants from municipal, provincial, and federal governments. It offers without charge a wide variety of individual and group rehabilitation services to the sightless.

Eligibility for services is based on an oculist's written report certifying blindness. A visual acuity of 20/200 in the better eye after the best possible correction, computed on the Snellen eye chart, or a visual acuity greater than 20/200 but with a visual field of 20 degrees in diameter or less is the legal term for blindness and for registration with CNIB.

Principal services include: counselling designed to assist in emotional and social rehabilitation; individual and group teaching, at the client's home or the central classroom, in home skills, crafts, typing and Braille; central sales service for obtaining and disposing of craft materials; administration of special public concessions; circulating post-free library of Braille and record books; job placement in industry or CNIB refreshment stands and cafeterias; part-time sub-contract and full-time sheltered shop employment; modern residences for permanent or transient accommodation; counselling for parents of the pre-school blind child and educational counselling to parent, teacher, and child for those of school age; summer camps and recreation programmes and facilities for all age groups. A hobby shop has been established at Toronto headquarters to provide training and skill in hobby crafts and pre-employment training for those who will later move into industrial or shop employment. Classes are given in wood and metal working, simple household plumbing, and electrical repairs.

The Institute also maintains an active public education programme in sight conservation and prevention of blindness. Eye examinations, transportation to clinical centres, and glasses are provided on the basis of need. The Eye Bank of Canada, recently established in conjunction with the Canadian Ophthalmological Society, arranges for corneal transplant surgery and a supply of post-mortem eyes from voluntary donors. A Low Vision Clinic was set up in 1957 to provide persons with residual vision with lenses of superior intensity to permit them to read where possible.

¹\$15,700.00 in round figures.

²\$9,250.00 approximately.

³\$3,220.00 approximately.

⁴\$3,230.00 approximately.

The national and provincial head offices are in Toronto. Field secretaries and home teachers (all sightless) located in principal centres assure maximum coverage of town and country. Field offices are maintained at: Barrie, Brantford, Cornwall, Hamilton,¹ Kingston,¹ London,¹ Ottawa,¹ Peterborough, Port Arthur, St. Catharines,¹ Sudbury, Toronto,¹ and Windsor.¹

People living in the various areas are eligible for the services listed, but there are limitations due to geographical locations, unless the person is able to leave his home either temporarily or permanently. Once registration is completed the local field staff visits each person at least once a year, but in the early stages of blindness and when a particular problem is presented more frequent visits are made. The staff of the local field office is augmented by staff from specialized departments at the head office, such as the Children's Department and the Employment Department. The agency has organized boards and committees in these areas and the local volunteers help to maintain the contact with the known blind people and also refer new applicants to the Institute. Since the loss of sight is often associated with loss of income and other social problems, the Institute is in constant touch with other agencies such as the health departments, and with welfare officers, service groups, and educational authorities. It also maintains a close association with local eye specialists and hospitals.

Peterborough County Programme

A district office in Peterborough with a field secretary and one home teacher serves the counties of Durham, Northumberland, Peterborough, Victoria and Haliburton. The field secretary keeps contact with 92 registered blind people, including six children of 18 years or less in the City and Peterborough County and provides them with counselling, emergency welfare, and job placement assistance. He also arranges for those eligible for services to obtain the residential services of the vocational and other rehabilitative services of the Centre in Toronto, the eye bank, as well as home teaching, the use of the Braille library, and home craft services. Those served must have vision of 20/200 or less as determined by an ophthalmologist. The field secretary also arranges preventive services for eye examinations with an ophthalmologist, treatment either under government legislation or through voluntary sources, and glasses for those with low incomes.²

Problems include finding employment for blind people and suitable accommodation. The local field secretary feels a residence in Peterborough would be of help. In the rural areas, where there are no full-time public health services and no public health nurses, some difficulty is experienced in finding all those eligible for assistance.

No charge is made to those served. All revenues obtained are forwarded to the central office in Toronto which finances the field offices and services in local areas. The approximate revenue of \$12,281.26 in the fiscal year ending March 31

¹Residence facilities.

²In Peterborough, the Kinsmen Club will pay for surgery and glasses prescribed (if vision less than 20/50) for those who cannot afford them on referral from doctors, the Health Department, and others. Approximately 15 were helped in 1962.

1962, came from the Peterborough Red Cross and Community Fund¹ and a grant from the County of Peterborough.² Total expenditures were approximately \$15,026.37.

Canadian Cancer Society

A district office of the Ontario Division of the Canadian Cancer Society is maintained in Peterborough to provide service not only to the unit in the City and Peterborough County but also to the units in Ontario, Northumberland, Durham, Victoria and Haliburton counties. It is staffed by a graduate nurse as a full-time executive secretary.³ The office serves as an information centre (Little Red Door) for the district and the executive secretary assists the local volunteer branches in the area to carry out their activities. The field staff from the Ontario Division office in Toronto visit the district offices regularly to help co-ordinate the work of the districts, units, branches, and sub-units throughout the Province.

The local volunteer branch in Peterborough provides a variety of services to cancer patients and their families, including free cancer dressings to patients at home, financial assistance to needy patients to permit them to travel to the Princess Margaret Hospital in Toronto or to the treatment clinic in Kingston, arrangements for financial assistance to needy patients for accommodation while receiving out-patient treatment at clinics in other centres, payment for up to one month for necessary housekeeping service,⁴ payment for up to two weeks for necessary home nursing,⁵ payment for certain drugs for needy patients, payment for an initial assessment and service visit to any patient by the Victorian Order of Nurses following admission to the Society's list, and friendly visiting to patients in their homes and in local hospitals. Personal needs and gifts are also provided from time to time.

The Society assisted in sponsoring the cancer follow-up clinics in Peterborough originally and now provides volunteer lay workers and volunteer nurses to assist in running them. The clinics have been described previously.⁶ The Society works closely with the doctors, the Victorian Order of Nurses, and the Princess Margaret Hospital.

The Society's education programme is an important one. It includes several public meetings with speakers and films, a booth, local fairs with pamphlets and people to answer questions, assistance to schools and nursing schools in preparing seminars and talks, and talks to service clubs, church groups, and other organizations.

Local funds are raised chiefly by a special campaign. Money from the districts is sent to the provincial office and drawn on as required for local branch

¹\$11,431.26.

²\$850.00.

³Approximately two-thirds of her time is spent in the Peterborough County Unit and the remainder in the rest of the district. The Peterborough Unit includes branches in Campbellford, Hastings, Havelock, Lakefield, and Norwood, as well as in the City.

⁴On a 24-hour-a-day basis. Arranged through the local National Employment Service Office or through personal contacts.

⁵On a 24-hour-a-day basis.

⁶See p. 189.

expenditures. The field office and staff are maintained directly by the Ontario Division. The 1962 financial statement for the Peterborough Unit shows:

Receipts	
Campaign	\$21,126.86
Bequests and interest	17.08
In Memoriam donations	687.05
	<hr/>
	\$21,830.99
Expenditures	
Education	\$ 2,164.55
Women's services	3,534.57
General overhead	714.53
Campaign	957.40
	<hr/>
	\$ 7,371.05

The Canadian Red Cross Society

The Peterborough Branch is affiliated with the Ontario Division of the Canadian Red Cross Society and is operated by a volunteer board and committees. Branch representatives are kept informed of national and provincial developments at regular meetings. Provincial committees assist the local branches in carrying out their activities and co-ordinate programmes, such as the Blood Transfusion Services, on a province-wide basis. The particular services provided by individual local branches vary depending upon the state of organization and local needs. All branches assist in disaster services, such as providing emergency food, shelter, clothing, and bedding. They also participate in the blood transfusion programme and, as requested, in the international tracing service. Other local programmes are decided upon by the volunteer branch executive committees.

As to financing, a local branch is given a campaign objective which is based on its requirements for conducting local programmes plus a portion of the divisional and national budgets. A large part of this latter amount is expended on all Red Cross branches covering technical costs of the blood transfusion programme and all costs in connection with disaster services. There are administrative costs for all of the other programmes as well and a local branch would benefit depending on which programmes they carried on. Approximately one-third of expenditures are local, one third provincial, and one-third divided between national and international work. Where a branch fails to meet its campaign objective it retains the full amount of the local budget and only remits to the divisional and national offices any surplus which, thus, may not equal the two-thirds scale. Local needs get first call on monies raised.

The Peterborough Branch has sponsored the Blood Donor Service for over two decades for the hospitals and community. It is now part of the co-ordinated

province-wide service. Regular monthly clinics are held.¹ Families hit by disaster are given help in emergency food, clothing, bedding, and shelter as needed,² and the Branch actively participates in the local Emergency Measures Organization programme. Emergency welfare is given to those in need in the form of vouchers for food, clothing, shoes, and fuel.³ Home nursing courses are sponsored. The Junior Red Cross programme in the schools had 166 branches with some 5,535 members in February 1963. Any money raised is on a purely voluntary basis and is expended on help to needy children in the area and overseas through the Fund for Needy Children at Home and Abroad.⁴ Two senior citizens' groups are sponsored.⁵ The water safety programme is vigorously supported.⁶ A loan cupboard of equipment for the home care of the sick is maintained.⁷

An abbreviated 1962 financial statement shows:

Receipts

Balance as of January 1, 1962	\$ 489.05
Peterborough Red Cross and Community Fund	33,649.00
Donations	516.51
Offsets	194.08
	<hr/>
	\$34,848.64

Disbursements

Blood donor programme	\$ 3,090.19
Individual welfare	3,762.34
Disaster service	310.59
Loan cupboard	391.02
Home nursing	28.36
Water safety	188.20
Maintenance, rent, supplies	4,314.54
Campaign expenses	300.00
Offsets	194.08
	<hr/>
Local Total	\$12,579.32
Remitted to Ontario Division for Ontario, national, and international purposes	21,960.00
	<hr/>
Grand Total	\$34,539.32
Balance as of December 31, 1962	309.32
	<hr/>
	\$34,848.64

¹3,333 donations in 1962.

²Nine families in 1962.

³433 occasions of assistance in 1962.

⁴In 1962, over \$1,200.00 raised for various purposes.

⁵See also pp. 201-202.

⁶Instructors' Course—33; Leaders' Course—16; Total Water Safety Tests passed—633.

⁷153 articles loaned in 1962.

Peterborough County Tuberculosis Association

The assistance of the Association in paying for chest films of various kinds and in providing a volunteer worker for the chest clinics has been described previously.¹ A tuberculin-testing programme is being carried on in some of the rural area schools in co-operation with their part-time medical officers of health. Financial assistance for transportation to sanatorium and personal needs are provided for needy patients. The members also visit homes and endeavour to provide whatever assistance they can to patients on their return from hospital. A combined newsletter is prepared jointly with the Associations in Victoria County and Haliburton County for distribution to municipal administrators, local medical officers of health, the radio and press, school nurses, association members, and larger contributors. A Baby Sitters Training Course was provided in co-operation with other organizations for 90 participants, of whom 70 graduated. Talks are given at the Teachers College in Peterborough and in other schools. Public education is carried on.

The Association has its own board, of which the Medical Officer of Health is a member, and is affiliated with the Ontario and Canadian Tuberculosis Associations. All funds are obtained from the annual Christmas Seal campaign. These are retained for use locally, except for amounts paid to the Ontario Tuberculosis Association. Because of the changing tuberculosis situation, the Association is facing the problem of how best to fulfil its functions and to expend the money collected. The Baby Sitters Course is one such innovation.

An abbreviated financial statement for the fiscal year, April 1, 1961-March 31, 1962 shows:

Receipts

Balance on hand March 31, 1961	\$16,561.01
Christmas Seal donations	13,052.25
Interest	211.38
Deposits general account	108.82
	<hr/>
	\$29,933.46

Disbursements

Programmes	\$ 2,729.38
Ontario Tuberculosis Association	1,550.99
Christmas Seal campaign	2,908.30
Administration and capital gifts to hospitals	6,370.28
Balance March 31, 1962	16,374.51
	<hr/>
	\$29,933.46

St. John Ambulance Association

The local branch has a trained volunteer first-aid group providing service as needed at public gatherings, etc., and also runs a number of training courses. Its

¹See p. 176.

funds come entirely from the allocation of the Peterborough Red Cross and Community Fund Campaign¹ and from course fees.

Welfare League

This is a volunteer group, largely composed of the wives of professional men, who have some limited funds for assisting special family need problems related to health. It works closely with the Health Department from whom many of its referrals come.

Private Homemaker Services

There were two organized private services in Peterborough in September 1962. The larger of these has been operating for ten years and has 40 to 50 older women on call for such services as practical nursing, light homemaking, and baby sitting.² The workers, many of whom are widows, are screened carefully and most have had registered nursing training, or practical nursing training with the Red Cross or St. John Ambulance Association. The service is essentially designed for emergency and short-term situations, though under special circumstances longer term arrangements are made. Housekeepers who are willing to live in and to provide long-term service are difficult to obtain. The proprietor, a doctor's widow, feels that some type of practical training course for women wishing to do this type of work would be of value. This private service is highly regarded by those who use it and is in great demand. By its private financing nature it serves largely those in middle and upper income groups. It serves communities as far away as Lakefield and Port Hope on occasion.

The other organized private service was not visited but is understood to have approximately a dozen workers on call.

Peterborough County Children's Aid Society

The Children's Aid Society staff of social workers is responsible for administering legislation concerned with general child welfare, foster home care, adoption placement, and assistance to unmarried mothers. The services in practice extend well beyond the legislative functions and include a wide range of family counselling services, services and assistance to unmarried parents, care for neglected children in foster homes, arrangements for and supervision of adoptions, and general investigations at the request of the Official Guardian and the Director of Family Allowances.

Approximately 100 children are in foster home care³ at any one time as wards of the Society and through private arrangements with their parents. The full maintenance, medical, and dental care of such children are covered by government grants. Parents are expected to meet all or part of this cost, according to their means. These funds account for about 80 per cent of the budget and come approximately 40 per cent from the Province and 60 per cent from the municipalities served. The medical care of children over three years of age is

¹For year ending October 31, 1962—\$2,291.20.

²1962 charges:

Light housekeeping—60 cents per hour; \$5.25 per day of 8 hours; \$6.00 for 24 hours.
Practical nursing—\$1.00 per hour; \$8.00 for eight hours; \$12.00 for 24 hours.
Baby sitting—50 cents per hour.

³Steps are always under way to maintain a supply of good foster homes.

arranged with the foster families' doctors. People are also encouraged to use the services of the Health Department Well-Baby and Child Health conferences. For children who are younger, care is arranged with two local paediatricians. These last also advise without charge on infants for adoption. The Society is fortunate in the interest and service given by these doctors well in excess of any remuneration. Dental care is arranged chiefly with younger dentists, some of whom wish payment and some of whom wish only partial or no payment for their work. Approximately one-half of staff time is spent on work with these children.

The other one-half of staff time is spent in work with children in their own homes in an effort to maintain the family unit. This work is supported from private funds, such as the Peterborough Red Cross and Community Fund allocation, bequests, and interest on investments, except for a general provincial grant of \$5,000.00 per year towards staff salaries. These funds account for about 20 per cent of the total budget. With the emphasis directed to keeping children in their homes whenever possible, this imbalance in availability of revenue in relation to the working time spent and actual need is a source of some concern.

Medical and dental care for these children present problems also, especially where families are on public assistance or in lower income groups. The City Welfare Department can pay only for emergency extractions and not for treatment or preventive care for those receiving assistance. The Medical Welfare Plan is open only to those receiving assistance or on means test-based allowances. Those in lower and middle income groups who are unable to enrol in prepayment insurance plans not uncommonly have difficulty in obtaining sufficient care. Were it not for the generosity of some of the doctors and dentists and interested groups, such as service clubs, the situation would be even more difficult.

Among the services felt to be needed are organized homemaking on some type of reasonable financial basis, which would enable families to be kept together in the event of illness of the mother either in the hospital or at home. A number of children come into care because of the absence of homemaking care and the situation whereby in-hospital care is covered by the Ontario Hospital Insurance Plan, whereas home nursing care is not, except for indigent patients. Thus, the pressures are to remain in hospital.

Drug costs are a problem of families just above the low-income levels. The Kinsmen Club assist the latter group but the former are ineligible for assistance.

It was pointed out that the existing government legislation, provincial and local, results in emphasis on financial assistance to people only after they have exhausted other means of support. There is little or no provision for preventive services in kind or as case work and counselling to prevent indigency from occurring. This means that groups, such as the Children's Aid staff have to try to fill the counselling and case-work gap¹ even though this is not their actual responsibility. Some of the municipalities in the county regard the provincial cost-sharing level as a maximum and provide no supplements. This in turn has health implications where drug, food, and other needs are affected.

The tendency for a rather unrealistic division of services for people was also pointed out. For example, unmarried mothers are likely to become involved with their physician, the City Welfare Department, the Children's Aid Society, a

¹For example, advice on budgeting.

maternity home, and possibly some others, all around one problem. A family in receipt of relief must go to several official and voluntary agencies for assistance in budgeting, problems related to housing, marital problems, health problems, and child caring problems, etc. It was felt that some division is necessary but, in some instances, these divisions are arbitrary and contrary to common sense. In this connection the Children's Aid Society has taken some steps towards meeting with representatives of some local agencies and with some provincial officials to see if more reasonable arrangements for providing help to people who need it can be arrived at.

Canadian Mental Health Association

The local branch and board were in the process of re-organizing themselves when visited in the autumn of 1962. The local branch is affiliated with the provincial and national organizations. In addition to public education through literature, periodic forums, and lectures, special workshops are held on request for groups such as teachers. For several years the local society had provided a monthly bus service for families and volunteer visitors to the Ontario Hospital in Kingston. The service for families is to be discontinued. Instead, visits to the old people's homes may be made. Among the needs noted by the branch is a more extensive mental health service in the schools.

Income in 1962 was received from the Peterborough Red Cross and Community Fund¹ and from memberships and donations.² Expenditures were for bus trips to the Ontario Hospital in Kingston, public meetings, literature, advertising, and the local White Cross office expenses.

Peterborough Red Cross and Community Fund

There is a combined fund-raising campaign for 17 City agencies. A thorough industrial and residential canvass is carried out. It is run by a Board of Directors representing the co-operating agencies and other knowledgeable citizens who study the budgets and programmes of the member agencies and advise them as to methods of more efficient administration. The 1962 campaign objective for the agencies in 1963 was for \$199,279.00.³ Approximately 98 per cent of the objective was reported to have been obtained in the Annual Report to contributors.

Among the problems faced is that of the growing demands for funds and increasing difficulties in raising them in this way. A number of those interviewed expressed the view that some of the services presently being financed at least partly in this way were basic community services and should be tax supported. There is also a growing feeling that some joint planning as to services and staff use is needed if existing gaps are to be filled and overlapping prevented.

Other Agencies

Other agencies which provide services with health implications are the Big Brothers, Alcoholics Anonymous, the John Howard Society, the Salvation Army, the Provincial Probation Service, the Young Men's Christian Association and the Young Woman's Christian Association.

¹\$2,000.00

²Approximately \$350.00.

³The Budget Committee reduced agency requests of \$214,000.00 to this amount.

The assistance of some of the service clubs has also been mentioned. Others are the Rotary Club crippled children's work, the Lion's Club Canadian National Institute for the Blind eye bank, and the Kinsmen Club safety work with the schools. Church groups also provide certain types of assistance to families with health problems among other problems.

Peterborough Health and Welfare Association

Informal supper meetings are held from time to time among members of the various official and voluntary health and welfare agencies. These are voluntary and are semi-social in character. Matters of common interest are discussed from time to time. An information booklet on community services was prepared a few years ago on a trial basis.

HURON COUNTY FIELD STUDY

SOME GENERAL FACTS

The County of Huron comprises an area of 1,295 square miles which extends along the central part of the eastern shore of Lake Huron for some 60 miles and runs 40 miles inland at the maximum point. To the north is Bruce County; to the north-east is Wellington County; to the south-east is Perth County; to the south is Middlesex County; to the south-west is a corner of Lambton County. The country consists of level to mildly undulating tableland lying between about 1,000-1,200 feet above sea level. The land in the south is rich clay and loam. The soil becomes lighter towards the north with sand, gravel, and some outcroppings of boulders. Most of the original forest covering has been replaced by farmland, though wooded farm areas remain. The climate along the shore is moderate in both summer and winter, but beginning about ten miles inland is a rain- and snowbelt area which is colder in winter and warmer in summer.

Historically, the area is known to have been visited by Champlain in 1618. However, the first settler did not come until 1826. With the founding of the Canada Company in 1828, settlers came in growing numbers to Goderich to clear the rich surrounding farmland area. The population grew steadily until it reached a peak of 76,526 people in 1881.¹ Subsequently it declined to only 43,742 people in 1941.² Since then it has gradually climbed to a figure of 53,805 people in 1961.³ This is an increase of over 9 per cent⁴ as compared with the population of 49,280 people in the 1951 Census. The urban dwellers in communities of 1,000 people or more accounted for approximately 33.7 per cent of the population; the rural non-farm group in smaller urban centres and on the outskirts of the larger centres amounted to about 29.8 per cent of the population; the rural farm people accounted for 36.5 per cent of the population. More precise study shows a steady growth in the larger centres and a gradual decline in the purely rural and smaller urban centres. Of the 1961 population, just over 41 per cent were under 20 years of age as compared with 39.5 per cent for the Province as a whole.⁵ Approximately 11.4 per cent were 65 years of age or more as compared with the provincial average of 8.3 per cent.⁵ About 80 per cent of the people are of British

¹Dominion Bureau of Statistics Census data.

²*Ibid.*

³*Ibid.*

⁴The percentage population increase compares with that of 35.64 per cent for Ontario as a whole between 1951 and 1961.

⁵Dominion Bureau of Statistics 1961 Census data.

Isles stock but, especially in the south, there are large numbers of people of German ancestry and smaller numbers of descendants of people from other parts of Europe. Huron County has a predominantly Protestant population.

Huron is a rich farming area, chiefly in dairy cattle, beef cattle, poultry barley, flax, beans, peas, and sugar beets. Hogs and sheep are also extensively kept. Milk products such as Cheddar cheese and butter are important, but less so than in some of the neighbouring counties.

Small manufacturing, however, is also important. In Goderich there are industries for producing road machinery, pens and pencils, wood products, feed and cereals. The natural salt deposits are extensively exploited and the port facilities have encouraged the building of grain elevators and oil transferring facilities. In the smaller urban centres industries include the manufacturing of coal and wood stoves, steel doors, leather gloves, furniture, shoes, boilers, tile and cement, mobile homes, and the processing of food products. There are Royal Canadian Air Force stations at Clinton and at Centralia near Exeter.

The area is well supplied with both hydro-electric power and natural gas lines. Ample water supplies for both drinking and commercial purposes are presently available or can be readily obtained.

The Canadian National Railway provides daily freight, express, and passenger service for Goderich.¹ The Canadian Pacific Railway provides daily freight and express service.¹ For three other towns freight service is available and for one there is passenger service. The closest large airport is the Crumlin Municipal Airport at London, but there is a small private field near Goderich. The Royal Canadian Air Force also makes facilities available in emergencies. Highway 21, the Bluewater Highway, runs north from Sarnia through the county via Goderich to the Bruce Peninsula. Highway 8 runs from Goderich through Clinton and Seaforth to Stratford and Kitchener. Other good highways and roads connect the various communities with the surrounding area. Bus and transport companies serve the larger towns. Goderich has a good freshwater port for trans-shipping grain, oil, and manufactured goods.

Goderich, the county town and main urban centre, has a population of approximately 6,360 people. It is approximately 143 miles from Toronto, 62 miles from London, 84 miles from Sarnia, 84 miles from Owen Sound, and 46 miles from Stratford. Other urban communities are Clinton with about 3,300 people, Exeter with about 3,000 people, Wingham with about 2,800 people, and Seaforth with about 2,200 people. Blyth, Brussels, Hensall, and Zurich each have over 700 but less than 1,000 people.

The cost of living is generally similar to that elsewhere in southern Ontario, though a bit lower than in Toronto. General shopping facilities in the towns, especially Goderich, are good. The people commonly go to the cities near the county for much of their shopping. There are good primary school facilities in the larger centres. Consolidation of rural schools is well under way, though some areas are reluctant to change. There are district high schools in Goderich, Clinton, Exeter, Wingham, and Seaforth.

There is a private business college in Goderich, and the Goderich Collegiate offers a commercial course. Two small schools for retarded children

¹Except on Sundays.

have been developed in Goderich and Wingham. Weekly newspapers are published in Goderich, Clinton, Exeter, Wingham, Seaforth, Zurich, Brussels, and Blyth. There are radio and television stations in Wingham. Outdoor recreational facilities are convenient.

PUBLIC HEALTH

Organization

Huron County has a full-time Health Unit¹ providing services for its 16 townships, five towns, and four villages. The Board of Health is composed of four members of the Huron County Council and a provincial government representative, for a total of five members.² The chief executive officer is the Medical Officer of Health and the secretary is the County Clerk-Treasurer.

Because the Board of Health is regarded as one of the standing committees of the County Council, its membership tends to change each year, with the exception of the provincial representative.³ This presents problems in continuity of policy and sometimes hampers the developing of new programmes or the altering of existing ones. The experience in most areas is that new members of boards with all the good intentions possible need a year of service before they become reasonably knowledgeable about health matters.

Initially, the Unit office was located in Clinton but since 1956 it has been in the County Building at Goderich. Branch offices for public health nurses are located in the public hospitals in Clinton, Exeter, Seaforth, and Wingham.⁴

Abbreviated Financial Statement for the Calendar Year 1962.

Revenue

Huron County Municipalities	\$40,935.55
Province of Ontario	42,006.87
National Health Grants	10,640.14
Plumbing Inspection Permits	4,368.00
	<hr/>
	\$97,950.56

Expenditures

Salaries	\$68,445.50
Transportation	13,811.27
Maintenance	5,884.94
Miscellaneous	9,808.85
(administration, Board of Health, audit fees, etc.)	
	<hr/>
	\$97,950.56

The revenues are sufficient for the base-line programme but funds for extensions and new programmes are more difficult to obtain from the Council.

¹Started on July 1, 1949.

²Usually divided into two members from urban communities and three from rural townships.

³The 1963 list of standing committees of the Huron County Council places the Board of Health third after the Roads and Huronview Committees.

⁴Rent for branch offices is entirely paid through a National Health Grant.

National Health Grants are only available if base-line staff requirements have been met and if the local area is prepared to share part of the cost.

The current practice of the Huron Unit is for the Medical Officer of Health to make recommendations for the annual budget, but the actual drafting of the budget is done by the Board Secretary, who is the County Clerk-Treasurer. Though he may follow the recommendation of the Medical Officer of Health, he need not necessarily do so. Of course, the budget submitted by the Board Secretary is subject to adjustment by both the Board of Health and the County Council. This situation, together with the changing character of the County Council itself, places the County Clerk-Treasurer in a very strong position in County affairs.

STAFF¹

<i>Classification</i>	<i>Full-time</i>	<i>Part-time</i>	<i>Total</i>
Medical Officer of Health	1		1
Other Physicians ²		7	7
Supervisor, Public Health Nursing	1		1
Public Health Nurses	7	2	9
Other Registered Nurses ³		1	1
Public Health Veterinarian ⁴	1		1
Chief Sanitary Inspector	1		1
Sanitary Inspectors ⁵	1		1
Secretarial and Clerical Staff	2	1	3
	<hr/> 14	<hr/> 11	<hr/> 25

The Board of Health appoints all staff members and can discharge them, with the exception of the Medical Officer of Health. The latter's appointment and discharge must have the approval of the Ontario Minister of Health. In other staff appointments and discharges, the recommendations of the Medical Officer of Health are usually but not invariably⁶ followed.

The staff base-line is for one full-time Medical Officer of Health, ten full-time public health nurses, including a nursing supervisor, three full-time sanitary inspectors, including a chief inspector, and two full-time and one half-time clerks. The obtaining of sufficient full-time public health nurses presents the most serious staffing problem. The turnover is two to three each year. Two part-time public health nurses and one part-time registered nurse are presently employed. This leaves a deficit of the equivalent of one full-time public health nurse. Because of the area of the County and population distribution the nursing quota based on a ratio of 1:5,000 is considered by the Medical Officer to be too low. A National Health Grant could be applied for to obtain further public

¹As of June 1962.

²Number varies from time to time. They assist in well-baby and immunization clinics and are paid on a sessional basis. Married women doctors and doctors working alone in a community have been found to be the most willing to do this work.

³Part-time service at immunization clinics.

⁴The Veterinarian has a Diploma in Veterinary Public Health.

⁵An additional inspector now training is expected to join the staff in 1963.

⁶The changing composition of the Board of Health was felt to make this power a cause of some staff uneasiness, especially for those members involved in enforcing regulations.

health nursing staff, except that this is possible only where the staff base-line is being met already. Factors influencing the nursing shortage are the semi-isolation and rural character of the area, and the tendency for younger single nurses to move fairly often until they marry. Married nurses provide an important part of the staff but pregnancy and family responsibilities affect their employment, sometimes even on a part-time basis. On the other hand, there is little turnover of supervisors. Incomes are comparable with other similar areas in the Province.¹

Qualified sanitary inspectors are scarce also. At present, the Unit has a deficiency of one, but a trainee is being sponsored. In general, inspectors rarely come from other places, and the best results have been obtained by sponsoring local trainees. Even so, some do not remain beyond their obligatory period but move to larger urban centres. Incomes present a problem,² chiefly related to the obtaining of suitable annual increments on an assured basis. Instead, these tend to be decided annually by the County Council.

There is also a Public Health Veterinarian, approximately 70 per cent of whose salary³ comes from a National Health Grant. At the time of the visit, this staff member was considering resignation because of reluctance by the Board and County Council to provide a modest increment to his salary, as recommended by the Medical Officer. Should he do so, there would be little likelihood of obtaining a replacement at the salary level currently offered, and a valuable programme would be seriously curtailed.⁴

Some more assured personnel and salary arrangements seem essential in areas like Huron County if sufficient, competent staff are to be obtained and retained.

Programmes

Communicable Disease Control

GENERAL

Reporting in general is incomplete but the major diseases are well reported. The childhood communicable diseases are well reported by the schools but to a lesser extent by the doctors. No routine visit to a home in which a communicable disease has been reported is made unless special circumstances warrant it. Except in special cases, such as chronic pediculosis or extensive impetigo, re-immunization after a communicable disease is left to the discretion of the principals.

The Medical Officer of Health is not a formal member of the staff of the area hospitals except of the Goderich one where he is on the Infections Committee.

¹Public health nurses—\$3,700.00 to \$4,800.00 per annum range with a 1962 maximum increment of \$150.00. Nursing Supervisor—\$5,000.00 to \$6,000.00 per annum range with increments usually but not always similar to those for staff nurses. Increments are decided upon annually by the County Council rather than on an assured basis.

²Chief Sanitary Inspector—\$4,600.00 to \$5,600.00 per annum range with a 1962 increment of \$100.00. Sanitary Inspector—\$3,600.00 to \$4,600.00 per annum range with a 1962 increment of \$100.00. Trainee—\$35.00 per week.

³1962 salary—\$6,600.00 of which \$4,700.00 was from a National Health Grant and \$1,900.00 from the County. Increments are decided on a yearly basis, as with other staff members.

⁴The Public Health Veterinarian did not resign.

However, the Unit's services are available on request in the event of a hospital infection problem and other problems.

Among the more common infectious diseases seen in 1962, 35 infectious hepatitis cases, including one death, and one paratyphoid fever case, emphasized the need for constant attention to matters of food and water control. Rabies¹ in animals also increased in 1962 to 33, and 27 people received treatment following exposure.

TUBERCULOSIS CONTROL

A diagnostic and referral clinic is held monthly at each of the four larger hospitals in the County.² The hospitals provide the space, X-ray equipment, and the services of X-ray technicians. A clinician comes from the Beck Memorial Sanatorium in London,³ and all films are read by the sanatorium staff. The Health Unit staff make appointments, send out recall notices to patients as requested by the chest physician, keep clinic records, and send a public health nurse and clerk to assist at the clinics. The Huron County Tuberculosis Association⁴ pays for all examinations and for any X-rays and the services of the sanatorium staff in reading them. It also covers travel costs and the cost of the sanatorium X-ray technician who attends the Exeter clinics. Reports on all examinations and X-rays are sent to the family doctors concerned. The services of the clinics at Clinton and Exeter are available to the approximately 2,000 Royal Canadian Air Force civilian dependents at the nearby air force stations.

A monthly clinic is also held at the hospital in Seaforth but no chest physician is present. Films and histories are sent to the sanatorium for interpretation. If indicated, referral is made to one of the other clinics for examination by a chest physician.

Patients requiring admission to a sanatorium go to the Beck Memorial Sanatorium in London as a rule. The Health Unit assists in making admission arrangements and keeps the tuberculosis and chest clinic case registers for the area. The follow up of contacts and home visits to discharged patients on chemotherapy as indicated are done by the public health nurses.⁵ The Huron County Tuberculosis Association covers transportation costs if these cannot be arranged personally.

Miniature chest film equipment has been provided in the hospitals by the Province for routine admission X-rays. The hospital provides the space and the X-ray technicians. The Province reimburses⁶ the hospitals for these films.

A Mantoux tuberculin testing programme is carried out annually by the Unit in each of the area secondary schools on all new students and on those who will be graduating or leaving during the year. Positive reactors and their

¹See p. 231, rabies control measures.

²At Goderich, Wingham, Clinton, and Exeter.

³Operated by the London and District Health Association. In the case of the Exeter clinic an X-ray technician from the sanatorium also attends, but the local hospital's X-ray equipment is used.

⁴See also p. 255. Films for patients going directly to the out-patient facilities at the sanatorium are also paid for.

⁵Drugs for those discharged by the Sanatorium are provided by the Province and distributed through the Sanatorium.

⁶Fifty cents per miniature film.

families are referred to the nearest chest clinic for follow up. Students of primary schools are Mantoux-tested every four years through arrangements with the Province's travelling tuberculosis clinic (mass survey).

Every two years a mobile unit from the Beck Memorial Sanatorium visits Huronview, the county home for old people, to carry out an X-ray survey. Records and arrangements for the follow up of suspects are a responsibility of the Health Unit. The Huron County Tuberculosis Association covers the cost of the mobile unit visit. In co-operation with the county jail physician and the Beck Memorial Sanatorium, the Health Unit gives tuberculin tests to all jail inmates. Positive reactors have a chest film at the Goderich Hospital. The Huron Tuberculosis Association helps to pay for the X-rays.

A mass tuberculosis skin-testing and X-ray survey of the County was conducted in 1960 by the Ontario Department of Health.¹ The Tuberculosis Association covered the costs of promotion and clinic accommodation. Such a survey is done on the average every four years.

Some of the larger industries receive biennial chest X-rays through the mobile unit of the Industrial Hygiene Branch of the Ontario Department of Health.² By means of a mobile X-ray unit, the same branch of the provincial Department of Health provides annual examinations for workers in industries exposed to silica dust, for example, foundry and monument workers.

VENEREAL DISEASE CONTROL

There are no public clinics. The programme is a small one and is limited to the follow up of contacts and occasionally of those who are delinquent in taking treatment. It is felt that the actual incidence is greater than the number of cases reported to the provincial Department of Health and, in turn, notified to the Health Unit.

IMMUNIZATION

There is no specific adult immunization programme but adults may come to the child health clinics for smallpox vaccination and for tetanus toxoid and Salk polio vaccine inoculations. The Salk programme was carried out originally through the Unit and inoculations continue to be available. By the end of 1962, over 70,000 doses had been given. Concern is being felt over the declining demand by adults for initial and booster doses because outbreaks elsewhere have so often proven a special hazard to young adults. Special immunization arrangements are provided on request for girls entering nursing and for special groups in the area.

Primary immunization and booster doses to infants and pre-school children are encouraged through the family doctors. The well-baby and child health clinics also offer immunization.³ Primary immunizations to those not previously

¹Seventeen previously unknown cases, of whom 8 were active, were found.

²The Sheaffer Pen, Dominion Road Machinery, and the Dominion Tar and Chemical salt plants in Goderich.

³See also p. 234. Antigens used are smallpox vaccine and the quadruple antigen of diphtheria toxoid, pertussis vaccine, tetanus toxoid, and Salk polio vaccine. Other are used occasionally as indicated.

protected are offered following school entry,¹ and booster doses are offered routinely every four years to all primary and secondary school children.² No school immunization services are provided for the schools³ at the two Royal Canadian Air Force stations, though immunization is offered at regular child health clinics on the stations for infants and pre-school children.

Sanitation

The over-all programme is supervised by the Veterinary Public Health Officer. He and the sanitary inspectors work closely together but they carry out the specific programmes for which their training equips them. The sanitary inspectors' functions consist of an increasing proportion of demand work as opposed to routine supervision.

WATER SUPPLIES

All of the larger centres have satisfactory water supply systems from a safety standpoint. There are 10 municipally operated public water supplies in Huron County, as follows:

	Source	Nature of System
Town of Goderich	Lake Huron	—settling basin and chlorination. New intake and filtration plant.
Town of Clinton	drilled wells	—no treatment.
Town of Exeter	combination of drilled wells	—no treatment.
	Ausable River	—filtration and chlorination.
Town of Seaforth	drilled wells	—no treatment.
Town of Wingham	drilled wells	—no treatment.
Village of Zurich	drilled wells	—no treatment.
Village of Hensall	drilled wells	—no treatment.
Village of Blyth	drilled wells	—no treatment.
Village of Brussels	drilled wells	—no treatment.
Hamlet of Egmondville	drilled well	—no treatment.

Privately operated communal water supplies⁴ include:

- (1) Police village of Crediton—2 systems, each having a drilled source.
- (2) Police village of Auburn—4 systems, each having a drilled source.
- (3) Police village of Dungannon—2 systems, each having a drilled source.
- (4) The six townships bordering on Lake Huron—50 part-time systems (approximated serving summer cottages only), each having a drilled source.

The Royal Canadian Air Force station at Clinton purchases its water from the Town of Clinton Public Utilities Commission. Chlorination is carried out. The

¹Smallpox vaccine, diphtheria toxoid and tetanus toxoid combined, and Salk polio vaccine.

²Smallpox vaccine when indicated and the triple antigen diphtheria toxoid, tetanus toxoid, and Salk polio vaccine.

³The Unit provides no school health services to the stations.

⁴The privately operated public systems serve about six to 20 households each.

Royal Canadian Air Force station at Centralia secures its water from drilled wells in Usborne Township, south-east of Exeter. Chlorination is carried out.

Rural supplies and a number of town homes on the outskirts have private wells.

The role of the Health Unit is to do routine inspections and inspections on request to determine whether any health hazards exist. Municipal and other public supplies are sampled 12 times a year.¹ Private supplies are tested only on request.² The Unit works closely with the Ontario Water Resources Commission.

Efforts to have fluoridation introduced in Goderich have so far been unsuccessful.

SEWAGE DISPOSAL

Inadequate environmental sanitation as related to the provision of water and to sewage and waste disposal is felt by the Unit to be one of its main problems and serious potential hazards to the public health.

The operation of municipal systems falls under the jurisdiction of the Ontario Water Resources Commission. The concern of the Health Unit is where health hazards exist because these systems are inadequate. It also deals with private septic tank and privy units. Municipal plants are as follows:

<i>Community</i>	<i>Type of System</i>
Goderich	Discharge of raw sewage into Lake Huron.
Clinton	Activated sludge treatment plant.
Exeter	Lagoon sewage system.
Seaforth	Primary treatment only with chlorination of effluent.
Wingham	Large municipal septic tank. (Plans underway for lagoon-type disposal plant.)
Royal Canadian Air Force station Clinton (non-municipal)	Activated sludge treatment plant.
Royal Canadian Air Force station Centralia (non-municipal)	Activated sludge treatment plant.

The other communities have no municipal systems. The older and larger urban centres are facing the problem that their systems are inadequate for increasing domestic and industrial use. The systems are not infrequently over-taxed and raw sewage is released into local bodies of water. A closely related problem is that of people living in the rural township areas adjoining the towns. With the growth of housing, there is often not sufficient space for proper septic tank tile beds. The ground is becoming saturated and a health hazard results. In other cases the soil structure makes extensive use of septic tanks a health hazard. None of the municipalities have by-laws concerning private septic tank units.

All new units are inspected by the sanitary inspectors under the Public Health Act, Schedule B. In the summer especially this takes a large part of their time.

¹Two hundred and sixteen inspections in 1962.

²Seven hundred and eighty samples taken in 1962.

Sewage disposal is a matter of growing concern to the Unit. There is close co-operation with the Ontario Water Resources Commission and the Planning Branch of the provincial Department of Municipal Affairs. A few large institutions such as Huronview, two district high schools, Ontario Hospital Goderich, the South Huron Hospital Exeter, and a few industries, for example, a cannery at Exeter,¹ have complete sewage and disposal systems of their own. The answer for the towns and villages lies in building municipal sewer and treatment systems, but these are costly items to undertake and some are reluctant to do so.

PLUMBING INSPECTION

In 1961 the plumbing regulations of the Ontario Water Resources Commission Act made plumbing inspection mandatory in all municipalities of Ontario. Previously, only the larger urban municipalities had an organized system of inspection, usually under the direction of a public works committee, and using master plumbers to provide the actual inspections. The 25 municipalities in Huron County felt that individually they could not provide a proper inspection service, and in 1961, under a County by-law, the Health Unit was delegated authority to carry out all plumbing inspection services in the County. Some four to five such inspections are made daily in the summer and it is felt by the sanitary inspectors that, because of the close relationship to septic tank supervision, this work fits in well with their duties.² An average of two "cross-connections" per year are discovered in the work. If uncorrected, a "cross-connection" results in the pollution of a communal water system.

MILK SUPPLIES

Approximately 25 to 30 per cent of the Public Health Veterinarian's time is spent on milk control. There are ten pasteurization plants³ in the County licensed by the provincial Department of Agriculture. Three use the high temperature flash method and the remainder use the lower temperature holding method. Samples are taken monthly for testing on four pasteurized products at the dairies—top cream, table cream, homogenized milk, and chocolate milk. The laboratory work is done in Stratford at an associate laboratory to the Ontario Department of Health. A thorough sanitary inspection of the dairies is carried out twice a year with follow up as indicated.

There are 50 raw milk shippers in the area who sell milk to the local dairies⁴. All shipping at present is in cans. Only one of the dairies⁵ has felt financially able to convert to bulk haulage equipment. Some farmers have installed large, bulk cooling systems on their farms. The Unit has a vigorous raw milk improvement programme, consisting of inspection visits to the farms twice a year with follow up as indicated, and raw milk samples taken at the dairies on each shipper's supply once a month. Because of the amount of laboratory work involved and difficulty in getting it done at Stratford, the Unit established its own laboratory in 1960 to perform gel tests and standard plate counts on raw milk. In 1961, 7.5

¹Town of Exeter provided these facilities for the cannery.

²In 1962, 1,913 inspections, including 797 of plumbing, were made. The remainder were of septic tanks and drains.

³Some pasteurized milk comes into the area from dairies in London. Pasteurization is supervised by the London Health Department.

⁴Some producers sell milk to Toronto dairies. They are checked by inspectors of the Toronto Department of Health.

⁵In early 1963, it purchased a bulk tank and truck for gathering milk from the six producers who ship to the dairy.

per cent of the samples were found to contain more than the 200,000 bacteria per millilitre¹ standard established by the Unit. A mastitis control programme for the County assures that milk from cattle with diseased udders is not used until the condition has been satisfactorily cured. This programme enables the Unit to both assist the farmers to improve production standards and to improve the quality of fluid milk going into consumer products. The number of producers has gradually come down but the total amount of raw milk shipped has increased over the last ten years. This has resulted from smaller producers unable to meet standards gradually leaving the field, and to an increase in the dairy herds of the larger producers who are able to install satisfactory equipment and to meet standards.

In general the larger dairies with qualified staffs present few problems of control and their products test well below the standard set by the Unit. Two of the larger dairies also have Royal Canadian Air Force contracts and must meet its standards of acceptability as well. Some of the smaller dairies have less satisfactory records. Several factors are involved. They have less money to spend on equipment and on obtaining qualified staff. Some are in areas where they are the only local dairy. This secure market reduces the incentive to improve standards in some cases. It is found that most of the contamination problems occur following pasteurization, from faulty use of homogenizers and fillers, from cracked bottles, and from storage at unsatisfactory temperatures until the consumers purchase the product. Though it is possible to withhold local approval of the plants for health reasons if they do not meet the set standards, this is sometimes difficult to enforce. Part of the problem is that no precise bacteriological standards are established in the Public Health Act. Local health units and departments set their own standards based on widely accepted levels. Recourse can, of course, be had to the courts but, as in other fields of health control, this is done only as a last resort when all other efforts have failed.

Only four or five of the shippers present problems. The big shippers are only too anxious to co-operate in maintaining standards but a few of the small ones with more limited financial resources have proven difficult on occasion. Gradually, however, the matter is being solved. Again legal action is only taken as a last resort.

Ice cream cannot be tested at present because the Stratford Laboratory cannot handle the additional work during the busy summer season when its heavy load of water testing is done. It is clear that a more satisfactory laboratory arrangement is needed for the area.

It is also clear that the task of health units and departments in enforcing standards would be easier if uniform health standards on raw milk and milk products were established for the Province as a whole. This would eliminate differences from one area to another and, therefore, a means of argument by a delinquent shipper or dairy. It would also eliminate personal pressures sometimes indirectly or even directly exerted on local health unit and department staff members responsible for enforcement.

¹One bad count (200,000) is permitted on any four consecutive samples. If a second one occurs in that period the shipper's milk is excluded from the market until it is found to be within the accepted standard.

However, the chief area where it was felt further improvement could be effected is that of education of the producers and dairy staff. This will reduce the human hazards, still the most difficult to control.

MEAT CONTROL

The Veterinary Public Health Officer has assisted the Town of Goderich in carrying on a programme of meat inspection since 1948 under a special local by-law on meat inspection. The introduction of provincial regulations on meat establishments has made possible a gradual improvement in the abattoirs elsewhere in the County. A number of unsatisfactory ones have been abandoned and others have been renovated. At the time of the visit there were 20 small slaughter-houses in the County, the largest being the one in Goderich which handles about 2,500 carcasses a year. The others altogether account for about twice as many more. Most were able to meet local approval. None were being federally inspected. There were also two poultry-killing plants, one of which had Health Unit sanction to operate. A turkey farmer in the County kills turkeys periodically without Unit sanction.¹

The Public Health Act places responsibility for locally killed and marketed meat on the local municipalities. This presents a problem because, though the public want the inspection of locally killed meat, local departments of health are reluctant to enter this field since the provincial Department has tended to turn this over to the Department of Agriculture. Also most of the local areas do not have a qualified person to do meat inspection. Meat inspection requires a skilled veterinarian. Even federal inspection only goes as far as the abattoir door. It has been the experience of the Veterinary Public Health Officer that the trucks used for transportation could be improved. On occasion these have been seen to have slimy floors and to be aesthetically unpleasant, though the meat would rarely be a health hazard if properly cooked before being eaten.

It was suggested that the Public Health Act requirement for an affidavit as to the source of meat, including canned meat, be more vigorously implemented. It was also suggested that existing regulations concerning dead animals are incomplete in that they are concerned only with animal diseases and not with human disease control. Moreover, unless unsuitable meat is dyed the regulations are almost unenforceable. The view was expressed that this should be a public health responsibility because human health is involved. Another problem is that federally inspected meat is only stamped on the quarters and, therefore, the smaller frozen sections do not have the stamp. They are only identifiable by the label on the package and this can be subjected to misuse by re-using the package. It was strongly urged that there be more extensive meat control and that this be done under general provincial Health Department direction to relieve local pressures sometimes applied when local health departments or units attempt to do something about local problems.

A further need was pointed out for a programme of inspection for freshly ground meat, such as hamburg and trimmings, to test for pathogens. At the present time, there is no way of knowing whether the meat used is properly inspected beforehand.

¹There is sometimes some reluctance on the part of local Boards and Councils to enforce regulations which may financially affect a neighbour.

RABIES CONTROL

Rabies has been a problem in rural areas throughout the Province in recent years. The experience in Huron County is that dog by-laws in themselves are of limited impact since there is no control of cats and of the numerous wild animals. Rabies in the area was found in 33 animals in 1962, including foxes, skunks, bovines, coons, cats, dogs, and rarely in chipmunks, and squirrels. None has been found in groundhogs. Twenty-seven exposed humans received the Semple vaccine course in 1962. No really effective control programme for the wild animal spread has yet been developed.

FOOD OUTLETS

These are checked once a year as to general sanitary conditions when they are licensed in the local communities with by-laws. Eight bakeries and 17 local plants are so supervised. The former are inspected routinely once a year and the latter quarterly. There are two beverage bottling plants which are inspected twice yearly. Otherwise visits are only made if a complaint is made. As yet there are no automatic food-vending machines in use.

Restaurants and hotels are inspected once or twice a year by the sanitary inspectors, and oftener if the work-load so permits. Otherwise inspections are done only as indicated or on complaint. The staff shortage and the pressure of other control work during the summer has meant that the routine inspections are done in the other seasons. This is a source of concern, since many of the health hazards are more likely to occur in the summer months because of the warmer temperature and the influx of tourists. As elsewhere the turnover of food handlers presents a health education problem. Efforts are made to handle this through the proprietors. On the whole, co-operation is good. The careless and even destructive attitude of some segments of the public, especially towards washroom facilities, makes sanitary control difficult at times.

One problem raised was the slowness in getting news of current food problems to local health departments and units. This was illustrated by the news of Salmonella contamination of certain types of cake mix which first reached the Unit staff through a newspaper report. Another difficulty is that some of the provincial legislation is general in nature. This means that from one jurisdiction to another there can be variation in interpretation and in the extent of enforcement.

SCHOOL AND HOSPITAL SANITATION

Eating and washing facilities in schools are checked annually. Those in the hospitals may be done only on request. Small rural schools and some small hospitals present sanitation difficulties which are hard to solve. Their buildings are often unsuitable to improve properly and financial resources are usually limited for doing so. The trend to central schools has helped but some municipalities have been reluctant to enter such programmes.

SWIMMING POOLS AND AREAS

Public swimming pools and beaches are checked regularly and on complaint throughout their season of use. So far these have not presented the same extent of problem found in larger centres and more populous tourist areas.

CAMPS AND RESORTS

Summer camps are inspected as to general sanitation, water, and food facilities annually for provincial licensing requirements and once or twice more if they operate through the entire vacation season. There are no particular problems.

GARBAGE AND RODENT CONTROL

Garbage collection is not a responsibility of the Health Unit. However, the municipal dumps are visited from time to time, or on complaint, to try to assure that proper measures to reduce rodents and other human health hazards are maintained. Some use acceptable sanitary land fill methods but most have only partial arrangements. Some communities have no regular collection system. The question of satisfactory refuse disposal methods is a growing one, especially for the urban communities.

HOUSING

Inspection is only carried out on request of local authorities or others to determine if a health hazard exists. It is difficult to demonstrate such a hazard. It is felt that more precise legislation on general housing standards is desirable. A national code is available, but there is hesitancy at municipal level to use it. Most of the problems seen are not primarily health problems but because of a relative absence of legislation and local enforcing officers, they are not uncommonly referred to the Unit.

AIR POLLUTION

This presents a problem intermittently. This most frequently results from uncontrolled fires at municipal dumps. The Industrial Hygiene Division of the provincial Department of Health has assisted the salt firm in Goderich in establishing a control system. Goderich also has a dust nuisance from time to time in the residential area near the harbour, resulting from the operation of the grain elevators and lake shipping.

GENERAL

One of the common problems in the entire field of environmental control is the lack of sufficiently precise provincial legislation definitions, and standards. This is understood to be under revision at present. The occurrence of new hazards, and changes in the nature of older ones, suggests that revision needs to be a regular undertaking.

It was suggested that one Veterinary Public Health Officer with good sanitary inspectors and laboratory facilities could provide a good food and environmental control programme for several rural counties on a regional basis. At present, people with this training are scarce and a number of rural units are without this type of staff member, even though the most effective development of a number of programmes is thereby hampered. It was also suggested that improvement in the status of sanitary inspectors and standard training arrangements across Canada were necessary if sufficient competent recruits were to be obtained.

Maternal and Child Health

PRENATAL PROGRAMME

Series of prenatal classes are conducted two to three times annually in each of the five larger communities. These are conducted in the local hospitals. The local doctors are asked to send lists of their pregnant patients to the Unit and the patients are then contacted about the classes. Many of the doctors actively encourage patients to attend. About 10 per cent of pregnant women do so. A visit through the hospital where delivery is to occur is included in the courses. So far no classes for fathers have been held.

There are no prenatal clinics at the hospitals. Medical supervision is provided only by the family physicians. The public health nurses make prenatal home instruction visits at the request of doctors.¹ In 1962, 306 women received such visits. The Victorian Order of Nurses has no programme in Huron County.

POST-NATAL PROGRAMME

There are public health nursing offices in the four hospitals outside Goderich. The public health nurses visit new mothers in all five area hospitals and arrange for home visits and baby care demonstrations as soon as possible after the mother returns home.² This has been done for many years, as agreed upon with the doctors when initiated. Almost every mother is seen. Subsequent visits are made as indicated. In general, the programme is well received. The Unit stresses the role of the family doctor in its visits and contact with the local doctors is close, partly because of the offices in the hospitals. On the other hand, in one hospital the nursing supervisor reported only limited contact with and referral to the public health nurse.

WELL-BABY AND CHILD HEALTH CLINICS

Clinics are held monthly in each of the five larger communities except during July and August. They are staffed wherever possible by local physicians paid on a sessional basis and by public health nurses. Primary immunization with smallpox vaccine and the quadruple antigen and booster doses are offered. Children requiring treatment are referred to family doctors. In 1962, 901 different infants and children were brought to the clinics. Some of the doctors prefer to have routine immunization of their infants and children done in this way. Others wish to do this themselves. The experience has been that some doctors encourage their patients to attend the clinics whereas others feel they may lose patients by doing so. In general, it has been easier to get practising physicians to assist at the clinics from communities where they are working alone. All immunization records are available to the family doctor on request. Occasional frictions have occurred in getting information from doctors where patients have gone to the clinic. Attendance at the clinics has remained fairly steady in recent years, though few children are brought after 18 months of age.

Adults may come to these clinics for immunization against smallpox, tetanus, and polio. As much as possible, they are encouraged to go to their family physicians for this protection.

¹Those not under medical supervision are urged to seek it.

²Five hundred and ninety-five infants under two weeks were visited, or about 54 per cent of eligible infants. No 1962 data are available on the further numbers visited under four weeks. It was about 58 per cent in 1961. See Appendix I, p. 181, footnote 2, for the method of calculation used.

INFANT BOARDING HOMES AND BOARDING HOMES FOR MOTHERS

There are no licensed homes in the County.

PRE-SCHOOL CHILD HEALTH PROGRAMME

As mentioned, the Child Health Clinics are available to older pre-school age children but few in fact attend after 18 months of age, except for immunization booster doses.

During the late spring, a letter is sent by the Health Unit to the parents of children who will be starting school in September and who live outside the Town of Goderich. They are urged to take the child to the family doctor for a physical examination and to bring immunization status up to date.¹ A dental check-up is also recommended. No special arrangements are made for children whose parents do not carry out these recommendations. However, the rural schools are visited during the first month in the autumn. The children are superficially screened by the public health nurse and any problems noted are referred to parents for action.

In Goderich, by special arrangement with the School Board, an organized pre-school "round-up" is held jointly between the schools² and the Unit. The parents are asked to come to the school with their child. There they and the youngster are first interviewed by the kindergarten teacher. An estimate is made of the child's sociability and extent of development of primary skills. Then the school public health nurse takes a health history and makes certain routine measures, such as weighing and measuring height. Last, the child is seen by the Medical Officer of Health who performs a rapid screening type of physical examination and gives any needed immunization inoculations requested. Any problems requiring correction and treatment are referred to the parents who are urged to take the child to the family physician. The main emphasis of the entire procedure is on the health education of parents, and the detection of remedial defects, including dental ones, so that these may be cared for before the child starts school. In 1962, 121 of 127 children starting school attended the "round-up" with one or both parents, an excellent result.

School Health Service³

School sanitation facilities and any meal facilities are checked regularly by the Unit sanitary inspectors as required by provincial legislation. Other services are based on agreements between the Board of Health and the various school boards in the County.

PRIMARY SCHOOL SERVICE

The public health nurses spend time in the urban schools on a scheduled basis each week. The rural elementary schools are visited within the first month in the autumn. Thereafter, they are visited every three months or

¹Approximately 75 per cent were estimated to have had an examination in 1962.

²Both public and separate schools.

³In 1962, there were 166 elementary schools with about 9,801 pupils. Approximately one-half were in rural schools with four rooms or less (182 classrooms), and one-half were in urban or central schools with five rooms or more (128 classrooms). Included are 11 separate elementary schools. There were approximately 3,400 students in five district high schools. No school service is given to the approximately 500 children at each of the two airbases.

oftener if indicated,¹ as, for example, where there is a new teacher. No routine school physical examinations are carried out by the Unit staff. Children are seen by the public health nurse on teacher referral and, if an examination seems indicated, the parents are urged to take the child to the family doctor. In Goderich only, a child so referred, for whom no examination has been arranged after a reasonable time, is referred to the Medical Officer of Health for examination with consent of the parents. Otherwise only children falling within the terms of the Communicable Disease Regulations, as for example, where there are questions of diagnosis or suitability for return to school, are seen by the Medical Officer.

Routine screening procedures by the nurses include vision screening, using the Snellen chart and "Good-lite" chart, done in Grades I, IV and VII. In co-operation with the provincial Department of Health, Mantoux tuberculin testing with a follow-up chest film for positive reactors is carried out every four years. No audiometric testing is done at present but simple voice tests are done in Grades I, IV and VII.

Primary immunization with smallpox vaccine, Salk polio vaccine, and combined diphtheria and tetanus toxoids is offered,² as well as booster doses every four years usually of the triple antigen³ or other antigens⁴ as indicated. Smallpox re-vaccination is offered every five to seven years.

Two school boards⁵ have an arrangement for examination and treatment for all pupils in local private dentists' offices. Thirty per cent of the cost is rebated by the Province through the Board of Health to these school boards. The other areas have no school dental programme other than general health education.

SECONDARY SCHOOL SERVICE

The high schools are visited by the public health nurses for one-half day each week. They see children only on referral by the school staff or parent. If a physical examination is indicated, the parents are urged to take the child to the family doctor. Routine vision and spoken voice screening is done in Grade X. Mantoux tuberculin tests are done annually on all new students and on those who will be graduating or leaving during the year. Positive reactors and their families are followed up at the chest clinics. Booster immunization inoculations are offered as for the elementary schools.

One of the growing components of the secondary school service is that of personal health counselling. Students are offered such a conference in Grade X and may also request one at any time. A source of concern for the schools and Health Unit has been the difficulty in obtaining skilled psychiatric, psychological, and social counselling for children whose problems required these but who were not frankly ill. For the seriously ill, referral has been made to the Ontario Hospital in London or to private psychiatrists in London. There were no mental health and care facilities in Huron County until January 1963. A new 300-bed

¹Some have only 12 to 15 pupils.

²See also p. 225.

³Diphtheria toxoid, tetanus toxoid, Salk polio vaccine.

⁴Salk polio vaccine, combined diphtheria and tetanus toxoids.

⁵Ashfield Township Public and Separate School Boards.

community psychiatric hospital¹ has been opened outside Goderich and it is intended to offer in-patient care as well as out-patient referral service and a day care programme.

GENERAL COMMENT

The programme is in general well-regarded by the doctors and the public. The former receive quite a number of referrals from it. The public health nursing shortage together with the numbers of small rural schools have resulted in the programme for these areas being fairly limited in content. The Unit staff and the school authorities would like to develop an audiometric testing programme, extend the nurse counselling in the secondary schools, and make some arrangement for pre-school and other children referred but not taken to their family doctors for examinations. Another problem is the absence of a preventive dental programme in most school board areas. It is difficult to arrange corrective treatment for children from low-income families and families on general public assistance. The latter are covered for emergency extractions only. In practice, this involves finding service clubs willing to assist financially in obtaining care, or private dentists willing to give care either free or at reduced cost.

The new Goderich Ontario Hospital should meet the mental health problems being found among school children.

There are no special classes in the schools for handicapped children, though certain equipment is available from the provincial Department of Education. There is a special opportunity class at the Goderich Public School only, which is referred to as a "remedial reading" class. For students of limited ability or performance who "transfer" from Grade VIII, "terminal" courses will be offered in 1963 at Clinton. This is a central vocational school to serve all the County except for the Wingham area where a similar school is under construction to serve North Huron and a neighbouring area, Bruce County. Private schools for retarded children are conducted at Wingham and Goderich.²

Public Health Education

This is largely done through personal contact. Mass media are used for special programmes, such as the Sabin vaccine one. Members of the staff take an active part in speaking to church women's service clubs and home and school groups on health matters as requested. For example, in 1962 the public health nurses alone spoke at 36 meetings.

Accident Control

There is no specific Health Unit programme other than by the nurses noting problems during home visits. There is no poison control centre at any of the area hospitals.

Public Health Nursing and Home Care

The area has no service by Victorian Order of Nurses. The Unit public health nurses will make an initial home visit at a doctor's request to cancer patients and to elderly people. They cannot promise to do anything further.

¹Part of the Ontario Hospital system. See p. 249.

²See also p. 258.

Cancer patients needing further care are referred to the local Cancer Society Branch who will make arrangements including financial assistance. Public health nurses also visit patients referred from the Regional Ontario Department of Public Welfare Office who are receiving Old Age Assistance, Disability Pensions, and Mothers' Allowance. The visits are chiefly concerned with matters of diet, medical supervision, and use of old age facilities. This programme started in October 1962. It is felt that a home nursing programme is one of the more urgent needs of this rural area. At present people must make *ad hoc* arrangements for nursing care with married nurses in the area. Particularly in the towns this is sometimes difficult to arrange. A study is under way by the Health Unit and the Children's Aid Society to try to determine the need for a home nursing service. The Health Unit is willing to provide bedside nursing care but cannot do so without further staff. The basic public health programme is hampered at present because of a shortage of public health nurses.

Homemaking service has been found to be needed under certain circumstances. The small Dutch Reformed Church congregation have their own homemaker. Otherwise, people have to try to obtain one as best they can. At present, family members and neighbours can often help, but for long-term care this is more difficult to manage. Also, in the towns especially, there are people without family members who can help. In particular, for low-income and welfare families this is a problem.

Mental Hospital Follow-up Work¹

The Unit is notified formally by the After Care Department of the Ontario Hospital in London when people from the area are admitted to hospital and discharged from hospital. The public health nurses will make follow-up visits as requested by family doctors or, where there is no specific doctor, by the After Care Department staff members who come to the area once a month. In 1963, Unit public health nurses will visit patients formerly seen by public health nurses from the After Care Department. A programme of follow up is now being worked out with the new Ontario Hospital at Goderich.

Nursing Home Inspection

The Unit staff inspect the six nursing homes in the area to see that they comply with the County licensing requirements on staff and sanitary facilities. They are visited annually by the Medical Officer of Health and by the sanitary inspectors, and quarterly by the public health nurses. The nurses also visit specific patients from time to time.

One registered home was visited. Among the problems mentioned were the lack of funds to assist operators with capital improvements, such as sewage disposal facilities or additional buildings, and for drugs for indigent and low-income patients. Patients on general public assistance have \$4.00 per day paid for their care by the provincial Department of Public Welfare. This is not sufficient to cover drug costs.² Cancer patients who cannot pay for drugs have these supplied by the local branch of the Canadian Cancer Society.³ Another problem is that the homes are caring for patients who would otherwise be in the

¹See also pp. 250-251.

²\$6.50 per day was suggested as more satisfactory.

³See p. 258.

hospitals and yet they are not generally recognized for payment by the Ontario Hospital Services Commission for care given. The Commission attempts to get people out of general hospitals once active treatment is no longer of value, but people are reluctant to leave because there is no insurance coverage in nursing homes. It was suggested that homes should be given capital aid in reaching set standards and that they then should receive payment for all care by the Commission at a satisfactory *per diem* rate.

Several of those interviewed felt that nursing homes should be closely tied to the hospitals to assure proper supervision and to facilitate transfer of patients from one to the other. It was pointed out that several of the homes provided limited care only, were overcrowded, and met only the minimum licensing standards. Few were equipped to care for younger patients with chronic illnesses.

Hospital Social Service

Though no formal hospital social service is provided, the presence of the public health nurses in offices in four of the hospitals has led to their use to a limited extent by a few doctors in gathering needed information on and making arrangements for patients. The Unit is prepared to extend this service as nursing time permits. It is felt that a qualified social worker attached to the Unit could be of considerable help not only to the Unit but also to the area hospitals and doctors.

Liaison with Other Community Health Services

The Medical Officer of Health is an advisory member of the Board of the Huron County Tuberculosis Association. There are good relations with the service clubs,¹ the Children's Aid Society,² and the local welfare authorities.³ Home nursing visits are made on behalf of or with the district nurse of the Ontario Society for Crippled Children, London.⁴ Visits are also made at the request of the Ontario Rehabilitation Foundation for the Disabled⁵ who have clinic services in London. The Ontario Cancer Treatment and Research Foundation holds follow-up clinics at the Wingham Hospital twice a month. The Health Unit is not directly involved in the clinic, but it is involved in visiting patients at home on request of the family doctor.

The Medical Officer of Health is a member of the County Medical Association⁶ and of the Goderich hospital staff. Relations are cordial with the practising doctors. Most of the doctors actively support and use the Unit's services for their patients. On the other hand, some have limited relations only.

PHYSICIANS

General

There are 33 active civilian physicians living in Huron County.⁷ There are four small groups or partnerships but the predominant pattern is of solo private

¹See p. 261.

²See p. 256. The Public Health Nursing Supervisor is an Associate Member of the Board of the Children's Aid Society.

³See pp. 251-252.

⁴See p. 259.

⁵See p. 259.

⁶A past president and secretary during the last four years.

⁷As of November 1962, ten in Goderich, of whom seven are in private practice; four in Clinton; six in Wingham; four in Exeter; five in Seaforth; five in smaller communities.

practice. Two doctors are certificated Royal College specialists who have combined general surgery—general practice patterns of work.¹ A third certificated general surgeon set up a purely specialist practice in 1962 in Goderich. A fourth certificated general surgeon practises as a radiologist with a small general practice.² Three are semi-retired and one of these serves as physician to The County Home, Huronview. One, the Medical Officer of Health, is in full-time public health work. There are also five active doctors from communities in neighbouring counties who have large practices and who are staff members of hospitals in Huron County. There is an active County Medical Association.

The Royal Canadian Air Force stations have their own medical services provided by five physicians. They rarely use the local medical or hospital facilities for those under their supervision.

Quite a number of the general practitioners do some general surgery. Almost all do minor surgery and obstetrics. Referral of tuberculosis cases is to the Beck Memorial Sanatorium in London, whose diagnostic and follow-up clinic services have been described previously. Mental illness referrals for diagnosis and treatment have been to London, either to private psychiatrists or to the Ontario Hospital. With the opening of a new Ontario Hospital at Goderich it is to be expected that much if not most of the referrals will shift to it, except for communities in the south of the County.

Most major surgical and other specialist referrals are to London. Some are with specialists in Stratford and Toronto. Cancer surgery and radiotherapy is done either at the Princess Margaret Hospital in Toronto or at the Victoria Hospital in London. The Ontario Cancer Research and Treatment Foundation operates the former hospital and supports a diagnostic and radiotherapy unit in London. A staff member from the latter conducts cancer case follow-up clinics in Wingham twice a month.

Once a week a radiologist from London comes to the hospital in Wingham to do diagnostic radiological procedures. All fracture and other films are sent to London for interpretation. In Goderich, X-ray work and interpretation is done by the radiologist in practice in the town. At the three other hospitals, radiological diagnostic procedures are done by contract with a travelling radiologist; other films are sent to radiologists in Stratford and London for interpretation. Occasionally, specialist surgeons or gynaecologists from London will come to a local hospital on invitation, but as a rule most work of this kind is done by local doctors or the patient is referred to London or elsewhere. None of the voluntary health agencies supports diagnostic clinics except for the referred chest clinics previously described³ in the County.

Comments

The area has a good supply of general practitioners, chiefly in solo private practice. The desire of most communities, even small ones, is to have their own local doctor. On the other hand there are a few groups and partnerships, none of more than three doctors, which try to serve wider areas than merely one town.

¹One in Goderich and one in Clinton.

²In Goderich.

³See p. 224.

Co-operation among the doctors appeared to vary from place to place as well as on an individual basis. Knowledgeable laymen who were interviewed sometimes remarked on the good relations among their area doctors. On other occasions the limited degree of co-operation was indicated as a problem, especially for a local hospital. In general, the doctors are staff members only of the nearest local hospital. In all five communities with hospitals, the doctors regarded the hospital with as strong parochial feelings as did the local people. It is felt that many would be reluctant to see the general nature of their own particular hospital restricted to that of a satellite hospital to a base hospital in Goderich, Wingham, or Clinton.

The relatively few certificated specialists, except surgeons, are a feature of the area. Though much work is referred to outside centres, some work is done which in larger communities would be restricted to those with special training and qualifications. Moreover, in certain emergencies a problem is presented because patients are too ill to be sent to London or Stratford. Yet this must be done or the local doctor must handle it. Most of the doctors would welcome specialist colleagues, especially in fields such as radiology and pathology. Some would welcome specialists in fields such as general surgery, obstetrics and gynaecology, paediatrics, ear, nose and throat, ophthalmology, and internal medicine, provided that the newcomers did little or no general practice. A few might be somewhat reluctant to have such specialists come to the area since this could mean some limitation on the extent of work now being done by them. Under present patterns in the area it is not easy for a specialist to restrict himself to specialist work alone, except possibly in the supportive fields of radiology and pathology. It will be interesting to observe how well the recently arrived surgeon, intending to do purely specialist practice, succeeds in his intention.¹ A number of the laymen interviewed would like to have basic specialist services more readily available, based in the largest town and hospital centre, Goderich. The towns close to London and Stratford would still prefer to use the specialist services of these communities.

Relations with the Health Unit in general are good. Some of the doctors use its services extensively and also assist part time in the clinics. Others have limited relations. Relations with the Beck Memorial Sanatorium in London are good. Some concern was expressed over the limited communication and reporting on patients admitted to and discharged from the Ontario Hospital in London. Reporting from the psychiatric section of the Victoria Hospital is good.

Among the problems in London noted by doctors is the difficulty in making home nursing arrangements since only the limited Health Unit programme is available on a formal basis. Dressings, and irrigating colostomies, etc., present a particular problem. Closely related is the question of obtaining homemaker service for the lower income and indigent groups. For wealthier groups some *ad hoc* arrangement can usually be made.

Alternative forms of accommodation for the chronically ill other than the general hospital are needed since only a proportion require the services of a hospital. At present, payment for accommodation under the Ontario Hospital Services Commission does not include nursing homes, though the provincial Department of Public Welfare makes payments towards the care of indigent

¹See pp. 238-239.

patients in registered nursing homes. This amount is low and standards of care are hard to maintain. Therefore, the doctors prefer to keep people in hospital as do the families of the patients. There are no facilities designed for younger people with chronic conditions who do not need general hospital care. Except for a full-time physiotherapist at the Wingham Hospital there are no special convalescent and rehabilitation facilities in the County. The Stratford Hospital has a Physiotherapy Department to which patients may be referred.

The only facility for the semi-senile and semi-ill is the County Home for the Aged. The incentive for the County is to keep them there, though it was not really designed for people who need nursing care, because the Province pays more towards their care than in a nursing home.

Also frequently mentioned was the lack of mental health consultation and treatment services. Presumably the new Ontario Hospital in Goderich will meet the problem.

DENTISTS

There are eight active dentists in Huron County.¹ None are dental specialists. The area has had difficulty in obtaining sufficient dentists, even to replace those who retire or die. Though some people go outside the area for dental care, the existing dentists have heavy work loads. Waiting lists are long and some dentists will give emergency care only to people who come to them from outside their own town and its immediate environs. Under these circumstances, it is difficult to maintain practice standards. It is difficult to obtain care for low-income families. A preventive dental programme by the Health Unit has been hindered since there would be little point in finding children in need of care unless sufficient treatment facilities are available. The Health Unit has been actively co-operating with the provincial dental organizations and the University of Toronto Faculty of Dentistry in an endeavour to ameliorate the situation.² Most people interviewed regarded the shortage of dentists as one of the more serious health problems in the area.

OTHER PROFESSIONAL AND TECHNICAL PERSONNEL

Registered nurses and registered laboratory and X-ray technologists are in tight supply. Qualified dietitians, physiotherapists, occupational therapists, medical record librarians, and social workers are either scarce or unobtainable. If it were not for married women with training in some of these fields, the situation would be even more acute.

HOSPITALS

There are five lay-owned public general hospitals in Huron County, the Alexandra Marine and General Hospital in Goderich, the Wingham and District Hospital, the Clinton Public Hospital, the South Huron Hospital in Exeter, and the Scott Memorial Hospital in Seaforth.

¹As of January 1963, Goderich - 3, Exeter - 2, Wingham - 2, Clinton - 1.

²A dentist for Seaforth has been obtained in this way but as of January 1963 he had not yet arrived. Some difficulty was being experienced on finding suitable living accommodation in the town.

Alexandra Marine and General Hospital, Goderich

The hospital has a rated bed capacity of 95 beds and 22 bassinets.¹

The average occupancy rate in 1962 was 78 per cent. The Hospital Board is composed of 18 members.² The hospital administrator has completed the hospital administration course provided by the Canadian Hospital Association. The non-medical full-time staff number 111 and are divided as follows:³

registered nurses	26
registered nursing assistants	18
other auxiliary nursing personnel	20
trained dietitians	1
registered X-ray technicians	1
non-registered laboratory technicians	1
others ⁴	44

The nursing situation is tight at times but sufficient nurses have been obtainable. There are about 35 married registered nurses in the town whose services are used as available. Some nurses from the United Kingdom are also on staff though they tend to stay only a year or so before moving to another community.

The medical staff includes the eight practising physicians in Goderich, one of whom is a certificated surgeon practising as a radiologist and two of whom are certificated and practising surgeons. The Medical Officer of Health is a member of the staff and is on the Infections Committee. Relations between the Health Unit and the hospital administration are close and frequent. As well, the Unit is invited to check on food handling and general sanitation in the kitchen and cafeteria. The public health nurses conduct prenatal classes at the hospital and visit maternity patients. The medical staff meets as a body monthly and there are as well several formal staff committees. These latter meet only infrequently when problems arise. There is no official chief of staff. The hospital is an open one and the Board have found the doctors to be reluctant to have medical staff by-laws too tightly enforced. On the other hand, it has been possible to establish general standing orders and a non-medical personnel policy.

The older section of the hospital was built in 1906 and contains the administrative offices, the chronic care beds, and nine private rooms. A well-equipped new section was completed in 1958 and contains the operating room, X-ray, laboratory, kitchen, and other service facilities as well as the remaining beds and the nursery. All pathological specimens are sent to the pathologist in Stratford. Because there is no supervising pathologist, the hospital laboratory only performs more straightforward procedures.⁵ More complex laboratory tests are done at an associate laboratory of the Ontario Department of Health in Stratford, operated by this pathologist. Blood transfusion supplies are arranged

¹ As of 1962—69 general beds, 24 chronic beds, 2 psychiatric beds. On the average, 95 beds were set up in 1962.

² Nine representing: the County—1, Goderich—1, Township of Colborne—1, Township of Goderich—1, Township of West Wawanosh—1, Women's Hospital Auxiliary—1, Goderich Graduate Nurses—1 Goderich Medical Association—2; and nine other members, three elected each year for a three-year term.

³ As at the end of 1962.

⁴ Maintenance, clerical, kitchen, orderly staff.

⁵ Some biochemistry, bacteriology, and limited histology.

through an area Red Cross office in London. Only short-term psychiatric cases are admitted to the psychiatric beds. The X-ray facilities are modern and are supervised by the staff radiologist. The hospital would like to obtain the services of a part-time physiotherapist and establish a formal medical record system. They feel they cannot maintain the services of a trained medical record librarian but could use a lesser trained person if qualified supervision were available.

The Hospital Board and staff wish to replace the older section as soon as possible and have already obtained about \$60,000.00 in gifts and from money obtained for care of semi-private and private patients. It is estimated that the new building will cost about \$320,000.00 and that grants will be available of \$2,000.00 from each of the federal and provincial governments, and of \$2,000.00 from the County and town councils combined. It is hoped to include not only 40 beds in the proposed section but also to have space for more specialized equipment required by potential specialist doctors. The possible inclusion of space for the Health Unit has also been proposed if further funds are obtained. The remainder of the capital funds for the building and for any special equipment will have to come from the local area through private and service club donations and from depreciation allowances on old equipment from the Ontario Hospital Services Commission.

The Hospital Board and Administrator would like to see closer operating relation with the other County hospitals and the eventual development of the hospital as an area base hospital with more specialized staff and equipment. At present the hospital is looked on as simply a local area one.

One of the immediate problems faced is that of chronically ill but semi-ambulant elderly people for whom general hospital care is no longer necessary. The absence of homemaking and of full visiting nursing services makes it difficult for them to go home. The County Home, Huronview, is designed to help well older people. Moreover, people are insured for in-hospital care but not for alternative forms of care and therefore are reluctant to leave the hospital.

The administrator feels an in-service staff training programme is needed to help keep staff up to date and to train ancillary personnel. As well some arrangement for sending staff nurses on special post-graduate courses would be helpful. Eventually the hope is to have the hospital meet the standards of the Canadian Council on Hospital Accreditation.

Relations with the community are good. The St. John Ambulance Association uses its facilities for first aid and home nursing classes.

Wingham and District Hospital

The hospital has a rated bed capacity of 93 beds and 10 bassinets.¹ On the average in 1962, there were 63 general beds, 67 chronic care beds, and 12 bassinets set up.² The average occupancy rate in 1962 was about 98 per cent.³ The

¹As of 1962: medical and surgical—25, obstetrical—10, paediatric—6, psychiatric—2, isolation—2, chronic—48, and bassinets—10.

²As reported in the 1962 Canadian Hospital Directory. The hospital feels these figures to be somewhat high.

³Up to 130 per cent in some sections, such as the chronic and medical surgical ones.

Hospital Board is composed of 15 members.¹ The hospital has a nurse-administrator. The non-medical full-time staff members number 140 and are divided as follows:²

registered nurses	19
graduate nurses (non-registered)	3
registered nursing assistants	40
non-registered nursing assistants	4
non-registered nursing orderlies	4
physiotherapists ³	1
medical record librarians	1
registered X-ray technicians	1
non-registered X-ray technicians	1
non-registered laboratory technicians	2
others ⁴	64

Registered nurses are in short supply and were it not for married nurses in the area and the extensive use of registered nursing assistants, other nursing aides, and orderlies, there would be serious staffing problems. Both laboratory and X-ray technicians who are registered are almost unobtainable. The hospital uses chiefly technicians trained in the area but without formal registration, though one X-ray technician is registered.

The hospital is an open one. The medical staff numbers 10 and includes all doctors in Wingham and those from neighbouring communities in Huron and Bruce counties. The medical staff meets as a body once a month. There are several staff committees which meet on an *ad hoc* basis when problems arise. There is a formal chief of staff. The Medical Officer of Health is not a formal member of the hospital staff but relations with the Unit are good. There is a public health nursing office in the hospital. The public health nurse conducts prenatal classes there and visits maternity patients. Food handling and general sanitation in the kitchen are now handled by the hospital laboratory technician.

The hospital was originally opened in 1906 in a house. This building was joined by a modern section opened in 1946 and now contains the operating room, X-ray, laboratory, administrative and other facilities, as well as the active care beds. The chronic care beds are in a wing constructed in 1955-56. All pathological specimens (tissues) are sent to the pathologist in Stratford, who is also the supervising specialist of the Wingham Hospital laboratory. Simple bacteriological and clinical laboratory examinations are performed. More advanced laboratory tests are sent to the laboratory in the Stratford General Hospital which is also an associate laboratory of the Ontario Department of Health and which is under the direction of the pathologist. Fracture and other standard X-ray work is done by the technicians and hospital staff doctors. Films are sent to a radiologist in London for confirmatory interpretation. Once a week a radiologist comes from London to carry out special diagnostic procedures, such as barium meals and enemas, etc. Major surgical and highly specialized procedures,

¹Eleven representing: the County—1, 1 each from nine local municipalities, and the medical staff—1. Four elected members, two each year for a two-year term.

²As of end of 1962.

³As of January 1963.

⁴Kitchen, laundry, clerical, housekeeping, maintenance and administrative personnel.

such as eye surgery, are referred to London. A cancer follow-up clinic is held twice a month in the hospital by the Ontario Cancer Research and Treatment Foundation staff in London. Appointments are made through the clinic. Approximately 40 people attend each clinic. Blood transfusion supplies are arranged through an area Red Cross office in London and regular donor clinics are held in Wingham.

The hospital has a provincially recognized course for registered nursing assistants. The course is ten months in length and there is room for 30 students in each year's course. The places are usually filled.

Aside from staffing questions, one of the problems mentioned is that of obtaining specialist medical care in serious emergencies. If the patient can be transported to London, this is done, since there are two ambulance services in Wingham. However, this cannot always be done and either the local doctors must try to cope with the situation or endeavour to get a specialist to come from London or Kitchener. More readily available specialist services were considered to be needed, especially for such situations.

Another problem is the care of older people who require more care than the County Home, Huronview, can provide but who do not need general hospital care. There is a lack of home care and alternative institutional facilities. A nearby private nursing home provides only limited registered nursing supervision and moreover usually is filled.

The nurse-administrator feels that the hospital's greatest need is for more beds and space.

Scott Memorial Hospital, Seaforth

The hospital has a rated bed capacity of 33 beds and 7 bassinets.¹ In June 1962 there were 48 general beds set up, including 8 chronic care beds. The average occupancy rate in 1962 was 96 per cent.² The Hospital Board is composed of 16 members.³ The hospital has a nurse-administrator. The non-medical full-time staff numbers 38 and includes the following:⁴

registered nurses	10
graduate nurses (non-registered)	2
registered nursing assistants	5
other auxiliary nursing personnel	3
non-registered X-ray technicians	2
others ⁵	16

¹As of 1962.

²Occupancy rates were:

Medical and Surgical 16.5 per cent (includes chronic),
Obstetrics 45.4 per cent,
Newborn 43.2 per cent,
Paediatric 59.7 per cent.

³Eight elected at annual meeting of the hospital association:—

1 appointed by medical staff,
5 appointed by area municipal council,
1 appointed by the county and
1 secretary-treasurer.

⁴As of end of 1962. Part-time personnel are also heavily used when needed and available.

⁵Kitchen, laundry, housekeeping, maintenance, and administrative personnel.

Almost all of the nurses are married and provide a varying amount of time each week. The situation would otherwise be serious. Auxiliary nursing personnel are widely used. Registered technicians are almost unobtainable and locally trained but unregistered personnel must be largely used.

The hospital is an open one and the medical staff numbers five. It includes all doctors in Seaforth and those from neighbouring communities. The medical staff meet informally about once a month. There are no committees otherwise. There is no formal chief of staff. The doctors are reluctant to establish more formal self-control measures since they feel themselves to be equals. The administration has not been able to establish a fully operative medical record system. The Medical Officer of Health is not a formal member of the medical staff but relations with the Unit are good. There is a public health nursing office in the hospital. The nurse conducts prenatal classes as demand warrants and visits maternity patients. The Unit has been requested periodically to check on food handling and general sanitation in the kitchen.

The hospital is housed partly in an old house donated in 1929 and partly in a wing built in 1947. Both buildings are quite unsuitable for their present use and present fire hazards as well. A 48-bed hospital is in the final planning stages and will replace the entire existing structure. It is estimated that it will cost \$662,000.00 for the building alone. Of this it is hoped to obtain about \$331,000.00 in federal and provincial grants and approximately \$96,000.00 from the County Council. The remaining \$235,000.00 or so and the cost of equipment will have to come from a local campaign¹ and other similar private sources. The County has to date refused to contribute any amount in excess of \$2,000.00 per bed. Also, though two-thirds of the patients are from outside the town of Seaforth, the surrounding townships give no direct financial assistance to the hospital. Some major surgery is done though facilities are limited. Most major work is referred to Stratford and London.

All pathological specimens are sent to the pathologist in Stratford, about 25 miles distant. There is no supervising pathologist, laboratory facilities are meagre and deal principally with urine specimens. Other clinical laboratory specimens are forwarded to an associate laboratory of the Ontario Department of Health in Stratford. The X-ray equipment is fairly old and only routine fracture and chest work is done. These are sent to London for confirmatory interpretation. A radiologist from London comes one-half day a week for gastric services, etc. Other radiological diagnoses are done in Stratford and London. The hospital would like to have a part-time physiotherapist in the new hospital. At present, patients must go to Stratford. Blood transfusion service is provided by the Red Cross through an office in London.

Among the problems mentioned, other than the building and staffing ones, was that of the care of elderly people who require some care but not general hospital care. The County Home is not designed for those needing much nursing supervision. The two private local nursing homes are crowded and have limited registered nursing supervision. Long-term homemaking services and visiting nursing services are unavailable.

¹A building campaign had received pledges of \$100,000.00 as of February 1963.

Clinton Public Hospital¹

The hospital has a rated bed capacity of 40 beds and 12 bassinets.² The 1962 average numbers of beds set up were 51 general beds and 15 bassinets.³ The average occupancy rate in 1962 was 94 per cent.⁴ The Hospital Board is composed of 12 members.⁵ The hospital has a nurse-superintendent. The non-medical, full-time staff numbers 55 and includes the following:⁶

	<i>Full-time</i>	<i>Part-time</i>
registered nurses	15	2
graduate nurses (not registered)	5	3
graduate nursing assistants	6	1
nurses' assistants	3	1
non-registered X-ray technicians	1	
non-registered laboratory technicians	1	
others ⁷	24	

As in the case of the three hospitals visited, the Clinton Hospital depends heavily on married nurses in the area and on auxiliary nursing personnel. Registered technicians and other skilled personnel are likewise almost unobtainable.

The hospital originated in a private house donated in 1908. Subsequently there have been extensive structural additions and renovations. A new wing to house additional service facilities and 20 beds is presently under construction.⁸ Considerable major surgery is carried out, though some work is referred both to Stratford and London. The hospital has good operating room, X-ray, and small laboratory facilities.

The hospital is an open one. The medical staff numbers six. All doctors in the town and in neighbouring communities are members. The medical staff meets as a body once a year. There are no active committees otherwise and no formal chief of staff. The Medical Officer of Health is not a formal member of the medical staff but relations with the Health Unit are good. There is a public health nursing office in the hospital. The nurse conducts prenatal classes there and visits maternity patients. The Unit has been requested on occasion to check on food handling and general sanitation in the kitchen.

All pathological specimens are sent to the pathologist in Stratford. Because there is no supervising pathologist, the hospital laboratory does only straightforward laboratory procedures and sends the remainder to an associate laboratory

¹Not visited by the authors. Data obtained through the Medical Officer of Health's assistance, and that of the hospital.

²As of 1962, medical and surgical—28, obstetric—8, newborn—12, paediatric—4.

³As in the 1962 Canadian Hospital Directory.

⁴Medical and surgical—108 per cent, obstetric—69 per cent, newborn—43 per cent, paediatric—51 per cent.

⁵Six elected annually, 1 appointed by the County, 2 appointed by the Clinton Council, 2 appointed by the medical staff, and the president of the Women's Auxiliary.

⁶As of end of 1962. Part-time nursing and other personnel are extensively used. For example, two registered nurses, three graduate nurses, one registered nursing assistant, and one nurses' assistant.

⁷Kitchen, housekeeping, laundry, maintenance, and administrative personnel.

⁸Estimated capital cost about \$300,000.00 of which federal and provincial grants are to cover about \$129,000.00, a County Council grant of \$40,000.00, and local campaign and gift sources approximately \$130,000.00. A campaign was in progress at the time of this study.

of the Ontario Department of Health in Stratford. Routine X-ray work is done and all films are sent to a radiologist in London for confirmatory interpretation. A radiologist from London visits once a week to carry out more complex diagnostic procedures. Cases needing physiotherapy are referred to London. Blood transfusion service is provided through the London blood bank of the Red Cross.

The Board feels that the medical staff is not sufficiently organized to assist in dealing with the problem of prolonged use of active type beds by chronic patients. They hope that medical staff will be better organized after construction is completed. They wish to pass by-laws that will regulate such functions as admission and discharge, and tissue work, etc.

For its part, the hospital has discovered in its fund-raising efforts that it has rather weak communications with the public. Public relations efforts are to be strengthened, though these are essentially directed to fund raising.

South Huron Hospital, Exeter¹

The hospital has a rated bed capacity of 52 beds and 14 bassinets.² The 1962 average of beds set up were 48 general beds, 8 chronic beds, and 14 bassinets.³ The average occupancy rate in 1962 was 64 per cent.⁴ The Hospital Board is composed of 20 members.⁵ The hospital has a nurse-administrator. The non-medical, full-time staff numbers 56 and includes the following:⁶

registered nurses	13 ⁷
graduate nurses (not registered)	1
registered nursing assistants	5
other auxiliary nursing personnel	15
non-registered X-ray technicians	3
others ⁸	22

As in the case of the three hospitals visited, the hospital in Exeter depends heavily on married nurses in the area and on auxiliary nursing personnel. In 1963, the hospital started a provincially approved course of ten months for registered nursing assistants.⁹ Registered technicians and other skilled personnel are likewise almost unobtainable.

¹Not visited by the authors. Data obtained through the Medical Officer of Health's assistance and that of the hospital.

²As of 1962.

³1962 Canadian Hospital Directory.

⁴Occupancy rates were: Medical and Surgical—76.7 per cent, Paediatric—40.2 per cent, Obstetric—57.1 per cent, Chronic—99.6 per cent, Newborn—37.8 per cent.

⁵Sixteen members elected at the Annual Meeting of the Hospital Association, 1 member appointed by the County Council, 1 member appointed by the medical staff, and 2 members appointed by the Women's Auxiliary.

⁶As of February 1963. Part-time staff are used as available and needed.

⁷Including nurse-administrator, her assistant and director of registered nursing assistant's course.

⁸Kitchen, housekeeping, laundry, maintenance and administrative personnel.

⁹Two courses a year of six months each were given previously for non-certified nursing assistants.

The hospital was built in 1953 and a new wing housing 16 beds was added in 1961.¹ The Royal Canadian Air Force station dependents from Centralia are also served by it. Because of its proximity to London, the original Board intended it to serve as a sort of "satellite" hospital to the teaching hospitals in the City. Little or no major surgery is done in the hospital but cases are referred to London. The hospital has good X-ray facilities, operating room and small laboratory facilities. Laboratory work is limited to urinalyses performed by nurses.

The hospital is an open one and the medical staff numbers 10. All doctors in the town and in neighbouring communities are members. The number also includes three non-resident physicians who use the hospital only occasionally. The medical staff meets as a body once a year. There are no active staff committees otherwise and no formal chief of staff. The Medical Officer of Health is not a formal medical staff member. Relations are limited with the Health Unit but there is the necessary co-operation for prenatal classes, chest clinics, and the visiting of maternity cases. There is a public health nursing office in the hospital.

All pathological, bacteriological, and blood specimens are sent to the laboratory of the Stratford General Hospital. Routine X-ray work is done but all films are sent to London for confirmatory interpretation. A radiologist from London visits for one-half day twice a month to carry out diagnostic procedures such as gastric series, barium enemas, etc. More complex diagnostic procedures are done in London. Cases requiring physiotherapy are referred to London. Blood transfusion service is provided through the London blood bank of the Red Cross.

One problem faced by the hospital is how to free active hospital beds that are being used by chronic patients. To date no committee for admissions and discharges has been organized by the medical staff. Another unmet problem is that a laboratory technician is needed at least part time by the hospital.

Ontario Hospital, Goderich

In mid-January 1963, a 300-bed mental hospital was opened just outside Goderich. It is the first of a new type of small, community-type hospital and will provide services for out-patients as well as in-patients. The staff are employed by the Mental Hospitals Branch of the Ontario Department of Health. It is expected that they will work closely with the area doctors, hospitals, and the Health Unit.

General Comments

The five general hospital administrators meet several times a year to discuss matters of common interest. However, efforts to bring about closer co-ordination of activity on a regional basis around the Goderich Hospital have to date been unsuccessful. The other hospitals are jealous of their autonomy. The doctors are reluctant to see their present practice patterns limited. The local people are proud of having their own hospital. Thus, parochial feelings of various kinds have largely resulted in independent efforts by the five boards and their doctors to build additions and to add further equipment and facilities.

¹Capital cost was about \$160,000.00, of which federal and provincial grants covered about \$70,000.00, a County grant of about \$32,000.00, and local campaign and gift sources about \$58,000.00.

However, in 1961, a committee representing the hospitals presented a proposal to the County Council for a 10-year programme of hospital financing which set forth their needs for expansion as seen by the individual hospitals, the estimated amounts of money which could be obtained from government grants, and the amounts of money which would be needed from local government sources and local fund drives.¹ It was suggested that the County Council was the best source for local government funds since at present the hospitals, though used by all the people in the area, largely get capital aid from the towns in which they exist and little from neighbouring townships. The proposed one mill County tax increase for this purpose has not as yet been accepted by Council. Some members feel this should be entirely the responsibility of higher levels of government. A minority of the hospital administrators and Boards have indicated interest in the benefits that might accrue from new community-based services, such as an organized bedside nursing and homemakers programme, and a professionally directed welfare unit to administer a comprehensive welfare programme in the County.

AFTER-CARE DEPARTMENT OF THE ONTARIO HOSPITAL, LONDON

The After-care Department, through the assistance of a national health grant, has been trying to follow up all patients discharged from the hospital on a regular basis in an effort to prevent serious relapses. Originally the staff of a psychiatric social worker and a public health nurse with mental health training visited all discharged patients themselves. Now that the programme has been developed they are trying to withdraw from direct service and to fulfil a consultative function to the various community services, such as the Health Unit, the local welfare officers, the special placement officers of the National Employment Service, the Children's Aid Society, the schools, and the clergy, etc. The family doctor, where there is one, is notified when a patient is discharged provided that there is patient agreement for this.² The Health Unit is notified of all admissions from the area and is informally told of discharges.³ They feel there is a definite role for public health nurses, who have been given a specialized course, to work in the mental health field on patient follow up following discharge and on minor mental health problems where hospitalization is not required. Thus, most of the field work is done by existing community services and the special after-care team spend their time with problem cases where a short time back at hospital may be indicated, with special investigation work, and with the consultative activities. In areas where there are not well-developed public health and other services, they continue to provide the direct patient service.

It was suggested that a travelling diagnostic service would not really meet the need of local communities because of the limitations on its availability and because no treatment could be given. Rather, psychiatric and social work services should be available all the time in an area. It was suggested that they be related both to the nearest Ontario Hospital and to the area Health Unit. This

¹Local canvasses and donations would be needed for furnishings and equipment.

²Some patients do not wish to return to a doctor who certified them for hospital admission.

³The practice varies from Ontario Hospital to Ontario Hospital at present. Some notify the Health Departments and Health Units; others do not.

last relationship would tie the clinic services more closely to the other community health services as well as to the large treatment hospital. In addition, a psychiatric section for short-term treatment was suggested for a central base-type hospital in each area.

One of their most difficult problems is with senile and semi-senile patients. The Ontario Hospitals are not the ideal place for their care but often there is no suitable alternative arrangement. The Huron County Home, Huronview, has a section for such patients provided that they do not require extensive nursing care and are not too difficult to manage. There is a close relationship between Huronview and the Ontario Hospital which permits ready transfer of patients back and forth as required. Relations with the hospitals are limited since the latter are not presently staffed or equipped to handle even short-term problems.

The teams serve some counties which unlike Huron have no full-time public health programme. In these counties, they find many problems in establishing a satisfactory local programme because of the absence of a county-wide organization with which to deal and the absence of public health nurses to do patient visiting. They also find that their relations with other organizations are less satisfactory where there is no health unit to act as an area clearing house.

The view was expressed that local communities and services could only become properly involved in mental health and mental care work if full-time public health services on an area basis were mandatory. Then definite policies could be established and precise financial arrangements developed for local areas.

OFFICIAL WELFARE PROGRAMMES

Regional Office, Ontario Department of Public Welfare¹

The district office in Wingham serves the three counties of Bruce, Huron, and Perth. The functions of the office are to handle applications and any local problems on the categorical allowances provided jointly by the Dominion and the Province,² and by the Province alone.³ In carrying out these duties, the people and families concerned are counselled as well as assisted financially. Through an agreement with the Health Unit, referrals are made of the names of recipients of allowances who wish a public health nursing visit. This has worked well and provided contact with people who otherwise are difficult to contact. Efforts are also made to find home help for those who are not eligible for official allowances. The office also generally supervises the administration of general welfare assistance by the area municipalities. The staff also supervise the accounts of indigents whose care they subsidize in licensed nursing homes. The case load is heavy⁴ and only limited case work is possible.

¹Not visited by the authors. Data obtained through the assistance of the Medical Officer of Health and the Regional Welfare Supervisor.

²Old Age Assistance, Disabled Persons' Allowance, and Blind Persons' Allowance.

³Mothers' and Dependent Children's Allowance.

⁴In the three counties served, this office has an active case load of 1,600, Huron County would contribute approximately 500 to 550 of these cases as follows:

	<i>Approximately</i>
Old Age Assistance	200
Disabled Persons' Allowance	200
Mothers' Allowance	85
Blind Persons' Allowance	15

The turnover in the County would be approximately 75 new cases per year.

The health-related problems faced by the staff are most common among the older age group of 65 years and over. These include lack of adequate medical and dental care and poor dietary habits. Untidy and dirty living premises are not uncommon, though these are rarely sufficiently bad to be an outright threat to health.

Local Municipal Welfare Services¹

The municipal clerk-treasurers frequently serve as the local municipal welfare administrators. They administer the statutory provisions of the General Welfare Assistance Act which provide for financial assistance to all those who qualify under the means test and who are not eligible under other federal-provincial programmes. Most municipalities now give some supplementary assistance to needy people on a shared basis with the Province.² Goderich provides a somewhat more extensive financial supplementary programme than do some of the other municipalities, and is thus able to keep at a minimum the number of nursing home cases, admissions to Huronview, and wards of the Children's Aid Society.

All recipients of municipal assistance are entitled to receive a monthly Ontario Medical Welfare Plan voucher form for medical services. Ontario Hospital Insurance Plan coverage is provided to recipients of municipal welfare when it appears they are a hospital risk. Costs of hospitalization for indigents not so covered are charged to the County and reimbursed by the Commission at the statutory indigent rate. Financing of dental care is limited to emergency extractions under general welfare legislation; but sometimes municipalities may cover other care in certain instances.

Any other services must be sought through the Health Unit, churches, service clubs, and other charitable groups. These include drugs, dental work, dentures, eye examinations, glasses, special equipment, transportation costs for care, food supplements, etc.

ACCOMMODATION AND OTHER FACILITIES FOR THE AGED

Huronview Home for the Aged

This modern and attractive home located on a 100-acre site on the outskirts of Clinton was opened in 1961. It is operated by the County for its residents, under the terms of the Homes for the Aged Act, for ambulant people over 60 years of age unable to support or fully care for themselves, for people over 60 years of age who are mildly senile but not mentally ill or defective, for people over 60 years of age who require bed care and general nursing but not needing skilled nursing or general hospital care, and for those under 60 years of age in special circumstances where they cannot otherwise be cared for. Admission is based on an application through the municipal welfare officers and in turn

¹Data obtained through the assistance of the Medical Officer of Health.

²For fuel, etc., in cold weather, and for prescribed medication in selected cases.

through the County clerk-treasurer and the Huronview Committee of the County Council. Medical examinations are required from the applicant's family doctor and the Huronview physician.¹

Seventy per cent of the maintenance costs are borne by the Province. People who are solely dependent on the Old Age Security Pension have all but \$9.50 per month of the \$65.00 total retained to assist with maintenance expenses. Those receiving categorical allowances, Old Age Assistance, Blind Persons' Allowance, or Disabled Persons' Allowance, have these discontinued. Any personal needs are provided by the Home or from families for this group. Residents with sufficient financial resources are expected to pay part or, if possible, all of the *per diem* maintenance rate, established from time to time. Those with assets must turn these over for administration to a county trust account or have someone with power of attorney guarantee their maintenance. In June 1962, approximately one-third of the residents were paying their own maintenance costs in full. Of the remainder, almost all were paying something towards the cost through the various pension deduction methods.

Medical care may be obtained from one's own physician or from the Huronview doctor. The latter calls twice a week and is on emergency call. Calls by the Home physician or by private physicians must be authorized by the Superintendent and are paid for at a set rate. Coverage under the Ontario Medical Welfare Plan is discontinued on admission to Huronview. An admission chest film and the initial admission examination by the Home physician are paid for by the provincial Department of Public Welfare. A bi-annual examination and chest film is also provided. Should hospitalization be required, residents are sent to the Victoria Hospital in London where they are cared for as staff patients on the standard ward. The out-patient facilities in London are also used. There are as well close relations with the Ontario Hospital in London and presumably will be with the new one at Goderich. The Clinton Hospital is not used because it has no staff beds and service would have to be paid for by the County. Moreover, the Victoria Hospital has a much wider variety of services available. The only cost to the County for residents sent to London is the \$20.00 ambulance charge.

One problem for the Home is that the area hospitals are anxious to discharge chronically ill patients who no longer require active treatment but who do need extensive trained nursing care, because of medical conditions, incontinence, etc. The nursing homes can provide some nursing care but because people have no financial coverage for this care, unless they are classed as indigents, they are reluctant to go. Moreover, the nursing homes are generally not overly attractive in terms of facilities and general amenities. Huronview, on the other hand, is not equipped to provide skilled nursing care, since its staff are not registered nurses, except for the matron. A home care programme it was felt would help to some extent only, since most of those involved in questions of care among Huronview, a hospital, or a nursing home require some sort of institutional facility. Many are senile or semi-senile.

Another problem is that residents tend to become ill in the winter at the same time as the Victoria Hospital is most crowded. On occasion this presents difficulty in getting a bed.

¹A semi-retired doctor who does no other practice.

The Home has room for 209 residents. As of February 1963, there were 192 residents. Vacancies were chiefly in the bed care section of 49 male and 69 female beds. The 28 special care (senile) places had a few places for men. The ambulant section of 60 beds had no empty places. The latter are free to come and go as they wish and are able. The average age of those admitted in the first six months of 1962 was 83 years. Almost all of the residents are in their eighties.

Most of the rooms are double rooms, though there are a few single ones and some four-bed rooms. There are also facilities for four married couples. Residents may not bring large items of furniture but small belongings, pictures, plants, etc., are permitted. There are balconies and gardens for sitting outside. The Home has modern kitchen, dining, toilet, and bathing facilities.

There is a tuck shop open at set times daily for snacks and small personal needs. There are also a chapel and a library. Larger sitting rooms have television sets and radios. A small craft shop is operated but is largely used by the women. The men appear to have limited interest in activities, such as gardening or carpentry, and prefer to sit, smoke, and play cards.

The staff, other than the superintendent and the matron (a registered nurse), numbers 72. Three are registered nursing assistants, four are orderlies, and the remainder are aides, kitchen and maintenance staff. Competent and personally suitable staff are sometimes difficult to obtain and retain.¹

In some quarters, the Home is still regarded as the "poor house" and there is reluctance to seek admission. The requirement that any assets be administered by the County also deters some people. However, attitudes have been found to be changing and more and more self-supporting people are applying for admission. It has been found that the residents miss familiar people and that visiting by family and friends is important to their well-being. There are no restrictions on visiting except in the special care section, for which there is a schedule. Church services are arranged through the local ministerial association. Church, service, and other groups visit from time to time and provide special entertainments, and small gifts, etc.

Relations with the Health Unit are limited except for routine inspection of the food handling and sanitation facilities.

Other Facilities for Older People

Other than programmes designed for the community as a whole, such as public health nursing, there are no specific facilities or clubs for older people. Seaforth has two apartments maintained by the town for older people. The Kinsmen Club in Wingham is reported to be considering the building under Central Mortgage and Housing Corporation regulations of 11 subsidized rental flats for well, elderly people.

A number of the professional and lay people interviewed felt that a greater variety of facilities and services for older people were needed, such as organized home care facilities, nursing home care on some better financing basis than at present and under the general supervision of the hospitals to assure better standards of care, and smaller homes in the main towns either under municipal or other auspices. Also needed are subsidized flats and services designed for middle-income older people.

¹Kindness and affection for older people is stressed.

OTHER VOLUNTARY HEALTH AND SOCIAL SERVICES

Huron County Tuberculosis Association

The assistance of the Association in paying for chest films of various kinds and their interpretation, and in providing volunteer workers for the chest clinics, has been previously described.^{1,2} The Association also pays for a biennial chest film for residents of the County Home. New staff and new residents are X-rayed prior to entering Huronview. Financial assistance for transportation to the sanatorium and personal needs and gifts are provided for needy patients. The members also visit homes and endeavour to provide whatever assistance they can to patients on their return from hospital. Some limited assistance is provided to cover such things as transportation for those taking vocational re-training under federal-provincial programmes.

The Association would like to see routine X-rays of food handlers and barbers. They would be prepared to cover the cost. However, the various municipalities would have to pass by-laws requiring this. Only some have done so to date. The Association would also like to see a tuberculin-testing programme on all children entering elementary school.

The Association is affiliated with the Ontario and Canadian Tuberculosis Associations but is fully autonomous with its own Board. The Medical Officer of Health is an advisory Board member. All funds are obtained from the annual Christmas Seal Campaign. These are retained for local use except for small amounts paid for affiliation to the provincial and national bodies. Because of the changing tuberculosis situation, the Association is facing the problem of how best to fulfil its functions and to spend the money collected annually. For example, in 1961, \$5,000.00 was contributed to one of the hospitals in the County for capital purposes. \$25,000.00 has been given to the hospitals since 1948. The possibility of making funds available for their reserves for medical or health research in the County is also being considered. There were three deaths in 1962 from tuberculosis in the County. The executive secretary feels that more intensive case finding is needed and that more money should be turned towards research.

An approximate financial statement for 1962 is reported as:

Revenue	
Christmas Seal Campaign	\$12,026.86
Bank and Bond Interest	313.22
	<hr/>
	\$12,340.08
Expenditure	
Assessments Ontario and Canadian Tuberculosis Associations	\$ 1,090.85
Referred clinics	3,300.00
Rehabilitation and social service	180.00
Educational material	450.00
Meetings and travel	300.00
Secretary, etc.	1,500.00
Ontario Tuberculosis Association for research and international purposes	5,000.00
	<hr/>
	\$11,820.85

¹See also p. 224.

²Approximately 900 chest X-rays, including referral clinic films and contact follow-up films are paid for annually. Hospital staff members have an annual chest X-ray paid for by the Association. X-rays for positive tuberculin reactors among jail inmates are paid for also.

Huron County Children's Aid Society

The Children's Aid Society has a staff of five social workers¹ and is responsible for administering legislation concerned with general child welfare, foster home care, adoption placement, and assistance to unmarried parents. In practice, the services extend well beyond the statutory ones and include a wide range of family counselling and social investigations at the request of the Official Guardian and the Director of Family Allowance.

Most of the time is spent in the child protection field. This concern is with non-wards, of whom there are approximately 60 under care at any one time.² Any home situation where children need special care comes within the Society's interest, for example, arranging for transportation to London for children needing special care, and contacting service clubs to obtain glasses and other appliances.

Children under care as wards are examined initially and once a year thereafter by the foster parents' doctors or by a doctor with paediatric experience arranged through the Society. The cost of wardship care is chargeable at a set *per diem* rate, to the municipality of residence³ of each ward and to the parents, to whatever extent possible. Provincial government grants of 40 per cent of the *per diem* costs, chargeable by the Society to the local municipalities, for wards are made to the local municipalities within the County.⁴ The *per diem* includes the maintenance, clothing, medical and dental care of these children. Ontario Hospitalization Insurance is applied for upon admitting the child to care. Families are also encouraged to use the Health Unit well-baby clinic and public health nursing services. Dental care is arranged with local dentists on an individual basis.

The care of children who remain in their own homes is supported from non-provincial funds, such as the County grant,⁵ except for a direct provincial grant of approximately \$3,500.00 per year towards staff salaries of protection workers. The provincial grant accounts for less than 5 per cent of the total budget of the Society. With growing emphasis on keeping children in their own homes, the imbalance in availability of revenue in relation to the working time spent and the actual need, is a source of some concern. Medical and dental care for these children cannot be provided by the Children's Aid Society except through service clubs, doctors, dentists, etc.

In helping unmarried mothers, the girl is helped to plan for her confinement and in making up her mind about the future of her baby. The parents of the girl often need as much counselling as she does. Rehabilitation of the unmarried mother is assisted also. However, no financial assistance is available unless the putative father agrees, or is required by the courts to

¹One is a graduate of a school of social work.

²There is a receiving home but there are never more than four children in it. They are moved as quickly as possible to supervised foster homes.

³Payment is made through the County Council and the cost assessed against individual municipalities as indicated.

⁴The Province also pays an annual unconditional *per capita* grant to each local municipality to help cover essential public services. Some of this money may be used to help cover statutory obligations for wardship care if so decided by a municipality.

⁵The County makes a general grant and also covers any deficit incurred. In 1962, the County made a grant of approximately \$2,000.00.

provide support. There are private and church homes for unmarried mothers in London, Chatham, Windsor, Hamilton, Ottawa and Toronto available to the Children's Aid Society.

There are no responsibilities for licensed boarding homes for children and day nurseries, since none exist in the County. There are a number of homes with fewer than four children being boarded but these are not covered by legislation.

One of the problems is that of arranging for transportation to special clinics in London. Appointments are obtained at the Victoria Hospital Clinics, Ontario Hospital, Children's Psychiatric Research Institute, and Child Guidance Clinic. The new Ontario Hospital at Goderich should eventually partly ease the situation. There is also need for more foster homes for emotionally disturbed children. These more difficult children form an increasing proportion of those coming into care as wards, since the majority of other child-care matters can be handled in Children's Aid Society foster homes, if not within the family setting. A special foster home for up to ten older children who are not suited to usual foster home care has also been suggested. This is being considered by a tri-county committee from Huron, Bruce, and Grey.

An abbreviated 1962 financial statement, in round figures, shows:

Revenue	
County of Huron ¹	\$42,105.00
Province of Ontario	3,500.00
Outside municipalities and Children's Aid societies	22,190.00
Parents	1,156.00
Family Allowance	1,864.00
Other	1,349.00
	<hr/>
	\$72,164.00
Expenditure	
Salaries	\$27,524.00
Travel	7,493.00
Rent	1,200.00
Clothing	3,209.00
Boarding homes	22,279.00
Medical and dental	1,690.00
Employee benefits	1,608.00
Workmen's compensation	417.00
Office supplies and telephone	2,107.00
Special needs	780.00
Wards over 18	216.00
Other	1,558.00
	<hr/>
	\$70,081.00

¹This includes the *per diem* amounts for wardship care chargeable to the municipalities of residence of wards plus a general County grant. In 1962, the latter grant came to about \$2,000.00. It is expected in 1963 that the *per diem* rate for maintenance of wards will be less than in 1962 and, therefore, the amounts collectable from parents and municipalities for wards will be less. This in turn means that a larger County grant will be required since the County grant is varied so that any deficit is covered.

Retarded Children

There are two schools for retarded children serving 12 children at Goderich and eight children at Wingham respectively. They are operated by a voluntary association of parents and other citizens.

They now receive some provincial and local grants.

1962 Financial Reports			
Queen Elizabeth School (for Retarded Children)			
Goderich and District			
Revenue		Expenditure	
Provincial Grant	\$3,500.70	Instruction	\$3,862.10
Council Grants	450.00	School Operation	289.74
Donations	1,069.76	Transportation	546.00
Fees	346.00	Other	482.82
1961 Balance	595.24	1962 Balance	781.04
	<hr/>		<hr/>
	\$5,961.70		\$5,961.70
	<hr/>		<hr/>
Golden Circle School (for Retarded Children)			
Wingham			
Revenue		Expenditure	
Provincial Grant	\$2,489.05	Instruction	\$2,900.00
Council Grants	625.00	School Operation	1,088.11
Donations	1,330.16	Transportation	—
Fees	275.25	1962 Balance	2,002.06
Other	46.00		
1961 Balance	1,224.71		
	<hr/>		<hr/>
	\$5,990.17		\$5,990.17
	<hr/>		<hr/>

Canadian Cancer Society

The organization and work of the Society in general has been described in Appendix I.¹ A district office of the Ontario Division of the Canadian Cancer Society is maintained in Kitchener to serve as liaison for the surrounding area, including Huron County. It is staffed by a graduate nurse. A field secretary from the provincial office in Toronto visits the district areas to help co-ordinate their work of providing information and of assisting local volunteer units and branches.

There is a local volunteer unit, with a volunteer board in Goderich doing the work for Huron County, and there are some branches in Wingham, Clinton, Exeter, Seaforth, Blyth, and Brussels. There is no paid staff in the County.

The branches provide a variety of personal services to cancer patients and their families in the towns served, including free cancer dressings to patients at home, financial help for needy patients for travelling to Toronto or London for treatment, assistance with the cost of needed housekeeping assistance, payment for certain drugs for needy patients, etc. As well, the volunteers visit patients in their homes and in the hospital and provide small gifts, flowers, etc.

¹See Appendix I, p. 211.

All local funds are raised by local drives, teas, bazaars, etc.¹ This money is sent to the provincial office and drawn on as required for local expenditures. The field office and staff are maintained by the Ontario Division.

Ontario Society for Crippled Children

The organization and work of the Society in general has been described in Appendix I.² The district office and staff of three nurses, and office staff of two in London serve the counties of Bruce, Elgin, Huron, Lambton, Middlesex, and Perth under the direction of the provincial office in Toronto. Approximately 1,409 children with physical handicaps were under care in the total area as of December 31, 1962. Service is given only on medical referral. The nurses work closely with the local service clubs³ sponsoring the Easter Seal Campaign in each area, with doctors, the health units, and other agencies working with crippled children. Assessment of cases in relation to the services offered and general follow-up supervision are also part of the duties. No bedside nursing care is given.

Fifty per cent of the money raised is kept locally for approved local work under the aegis of the sponsoring clubs, such as providing appliances, braces, wheel-chairs, X-rays, transportation for special treatment and to rehabilitation centres, and camp holidays. The other 50 per cent is sent to the provincial office in Toronto to support the district nurse programme and the other province-wide services provided directly by or supported by the Society.

The 1962 approximate costs for the London district office were:

Salaries	\$21,660.00
Office	780.00 (rent free)
Travel and car maintenance	3,876.00
	<hr/>
	\$26,316.00
	<hr/>

Rehabilitation Foundation for the Disabled (March of Dimes)

The organization and work of the Foundation in general has been described previously in Appendix I.⁴ Huron County is covered by the London office which also serves the counties of Lambton, Kent, Middlesex, Elgin, Oxford, and Norfolk. There is no district rehabilitation centre as yet, but physiotherapy departments in hospitals at London and Windsor are used. Long-term cases are sent to the Hamilton Rehabilitation Institute and to Lyndhurst Lodge Hospital in Toronto. Clinics, surgery, and brace and limb fitting are taken care of through weekly clinics at the Victoria and St. Joseph's hospitals in London under the supervision of the Foundation's medical advisor. A workshop is to be opened in London in 1963. There were 78 known cases in Huron County in 1962, of which 18 were being actively handled in the year. The March of Dimes campaigns in the County raised \$1,984.00 in 1962. The cost of services to cases was \$1,591.50.

¹In 1962, \$19,307.94 was raised from the unit and branches in Huron County.

²See Appendix I, p. 205.

³Lions Clubs in Huron County. \$8,497.93 was so raised in 1962.

⁴See Appendix I, p. 206.

Canadian National Institute for the Blind

The organization and work of the Institute in general has been described previously in Appendix I.¹ Huron County is serviced by the district office in London with a staff of field secretary, assistant field secretary, and home teacher. In the year ending March 31, 1962, there were 64 registered blind people in Huron County, of whom two were children of 18 years or under. There were also eight preventive care cases. There is no ophthalmologist in Huron County so residents are sent elsewhere for care. Funds in Huron are obtained from the County Council and from a public canvass by mail. In the year ending March 31, 1962, \$6,931.90 was raised in the County and \$8,210.46 was spent locally on cases.

The Canadian Red Cross Society

The organization and work of the Society in Ontario has been described in general previously in Appendix I.² There are organized branches at Seaforth, Gorrie, and Varna in Huron County. All assist in the basic programmes of fund raising, disaster services through providing emergency needs as required, the blood donor service, and, as required, the international tracing service. The Seaforth and Gorrie Branches carried out an active water safety programme as well.³ The London Area Branch serviced other communities in the County,⁴ which provided volunteer workers, blood donors, and raised funds under its aegis. As well, the Junior Red Cross programme had 223 branches with 6,494 members in February 1963. They donated money separately for the "Fund for Needy Children at Home and Abroad".

Campaign statistics in 1962 were in round figures:

Red Cross Branches (Gorrie, Seaforth, Varna)	\$1,948.00
Collected by London from other communities	\$7,136.00
	<hr/>
	\$9,084.00
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St. John Ambulance Association

There is a local brigade in Goderich of the St. John Ambulance Association providing first-aid service at public gatherings and offering first-aid and home nursing courses from time to time. It is hoped to establish brigades in Wingham and Exeter in 1963.

The 1962 financial report in round figures shows:

RECEIPTS

Campaign	\$1,240.00
Class fees	192.00
	<hr/>
	\$1,432.00
	<hr/>

¹See Appendix I, p. 209.

²See Appendix I, p. 212.

³Seaforth—143 successful award candidates. Gorrie—22 successful award candidates.

⁴Belgrave, Blyth, Brucefield, Brussels, Centralia, Centralia R.C.A.F. Station, Clinton, Clinton R.C.A.F. Station, Dashwood, Exeter, Goderich, Hensall, Wingham and Zurich.

EXPENDITURES

Contribution to brigade	\$ 900.00
Instructors and examinations	82.00
Supplies and equipment	230.00
Travel	30.00
Advertising, office supplies, and miscellaneous ..	83.00
Balance on hand	107.00
	<hr/>
	\$1,432.00
	<hr/>

Other Organizations

As elsewhere, the various service clubs have health and welfare programmes. The Canadian Legion and the Kinsmen will provide wheel-chairs, crutches, hospital beds, and pay for home care services for needy people as referred by doctors, the Health Unit, etc. The Lions are the local agents for the Easter Seal Campaign for crippled children's work. They also provide eye examinations, glasses, and on occasion pay for treatment of referred needy cases. The Odd Fellows and Rebeccas provide hospital beds, wheel-chairs, and loan cupboards in Goderich and Exeter.

The five volunteer forces raise money for the Muscular Dystrophy Association of Canada. The London Chapter of the Canadian Cystic Fibrosis Foundation services Huron County.

DISTRICT OF TIMISKAMING FIELD STUDY

SOME GENERAL FACTS

The District of Timiskaming or Temiskaming comprises an area of 5,896 square miles in the north-eastern part of the Province of Ontario. Its eastern boundary is also that between Ontario and Quebec. To the north is the District of Cochrane; to the south is the District of Nipissing; to the south and west is the District of Sudbury. The Canadian Shield underlies the area. Most of the surface is covered with forests of mixed softwoods, conifers, and a small amount of hardwoods which are interrupted by out-croppings of rock and by lakes. In the southern part, the Lower or Little Clay Belt extends south from Englehart to North Cobalt and west for a distance of 25-30 miles at its maximum width. The climate is pleasant in summer and cold in winter but the weather is less extreme than in places such as Winnipeg and Edmonton.

The 1961 Census figures show a population of 50,971 people as compared with 50,016 in 1951, an increase of just under 2 per cent in the decade.¹ Most of the people live in urban communities of 1,000 people or more (65.2 per cent). The rural farm population represent 10.8 per cent and the rural non-farm population represent 24.1 per cent of the population. Of the latter, a large proportion live in small villages and hamlets of under 1,000 population. In common with most of the northern areas there is a slightly greater proportion of males than for the Province as a whole. Moreover, nearly 45 per cent of the inhabitants are under 20 years of age as compared with 39.5 per cent for the Province as a whole.² On the other hand, approximately 6.9 per cent were 65 years of age or more, as compared with the provincial average of 8.3 per cent. Approximately one-half of the people are of British stock, 30 per cent of French ancestry, and one-fifth of other extraction. The bulk of the population are English speaking or bilingual.

The 1959 labour force estimated to be 17,100 was chiefly engaged in the natural resource industries of mining, lumbering, and agriculture. About one-quarter of the labour force is employed in mining, which is the chief industry, particularly gold mining. Most of the productive mines are in the north-east, extending from Matachewan east through the large Kirkland Lake - Larder Lake - Virginiatown fields to the Quebec boundary. Some of the older

¹Dominion Bureau of Statistics Census data for 1951 and 1961. The percentage population increase is low compared with that for Ontario as a whole, which is 35.64 per cent.

²Dominion Bureau of Statistics 1961 Census data.

mines have reached their economic exploitation limit and have closed during the last few years. Several marginal mines are operating only because of the assistance of the Emergency Gold Mining Assistance Act. The fixed price for gold in United States dollars has not encouraged expansion of existing properties and prospecting for new ore bodies. About one-third of Ontario's annual gold production comes from this area.

The Cobalt and Gowganda areas to the south and south-west produce over 70 per cent of the annual silver production and about 36 per cent of the annual cobalt production in Ontario. Recent improvements in the market for silver have resulted in the re-opening of some mines and the opening of some new mines in the Cobalt area.

The recent discovery of extensive iron ore deposits some six miles south of Kirkland Lake, and the decision to bring these into production, offer new hope for mining development in the future. The Timiskaming District also produces all of Ontario's arsenic output.

The primary forest industries are not as important as in the other districts of northern Ontario. On the other hand, about one-half of the larger secondary industries in urban centres are concerned with the processing and manufacturing of wood products.

Farming is an important activity in the Little Clay Belt area, particularly dairy farming. Other livestock farming is increasing. There is widespread growing of hay and some mixed grain. Hampering expansion is the shortage of farm workers who have been attracted by the more favourable job opportunities in mining and the various small industries.

Practically all of the industrial activities are related to the mining, forestry, and farming fields, either in processing or in providing necessary supporting services.

The area is well supplied with hydro-electric power and there is considerable potential for expansion of this type of energy as demand increases to make further development economic. The Trans-Canada Pipeline goes through the area and low cost natural gas is available in most of the larger communities. Water for drinking and commercial purposes is available in ample amounts.

The Ontario Northland Railway provides rail service. Trans-Canada Airlines provides a regular passenger and freight service to other parts of Ontario and Quebec through the airport at Earlton, about thirty-five miles south of Kirkland Lake. Several private airlines also serve the area. The modern highway facilities are good. The main highway is No. 11 which extends from southern Ontario through to Cochrane. Highway No. 66 joins the area to the neighbouring Rouyn-Noranda area of Quebec. Highway No. 17 runs through to the head of Lake Superior.

The main urban areas are Teck Township which includes the Kirkland Lake Post Office with a population of nearly 17,600 people, New Liskeard with approximately 4,600 people, Haileybury, the administrative centre, with approximately 2,700 people, and Cobalt with approximately 2,500 people. Other urban

centres include Englehart, Larder Lake, Virginiatown, North Cobalt, Matachewan, Elk Lake, Earleton, Latchford, and Gowganda. The cost of living is generally similar to that in southern Ontario. Housing tends to be cheaper but fuel oil and coal are more expensive. Shopping facilities in the larger communities are good. In addition to the primary public, separate and secondary schools in Kirkland Lake, New Liskeard, Haileybury, Cobalt, and Englehart, there are the Provincial Trade School in Kirkland Lake and the Provincial School of Mines in Haileybury. A daily newspaper is published in Kirkland Lake and a weekly one in New Liskeard. There is a radio station in Kirkland Lake, and television stations in Timmins and in nearby Quebec serve the area. Outdoor recreational facilities are convenient.

PUBLIC HEALTH

The Timiskaming Health Unit

Organization

The Timiskaming Health Unit provides full-time public health services for some 47,344 people¹ in 75 of the incorporated and unorganized municipalities in the District.² These include the largest population centres of Kirkland Lake, New Liskeard, Haileybury, Cobalt, Larder Lake, Virginiatown, and Englehart. The

¹As estimated in the Annual Report of the Board of Health for 1962, 43,107 in 23 organized municipalities and 4,237 in unorganized areas. The remainder of the District's people (3,274) live in areas outside the Health Unit.

²Municipalities and Townships in Unit, 1962.

Armstrong Twp.
(incl. Earleton
police village)
Arnold Twp.
Asquith Twp.
Barber Twp.
Barr Twp.
Bayly Twp.
Beauchamp Twp.
Benoit Twp.
Bernhardt Twp.
Blain Twp.
Boston Twp.
Bryce Twp.
Bucke Twp.
(incl. North
Cobalt P.O.)
Cane Twp.
Catharine Twp.
Chamberlain Twp.
Charlton T.
Chown Twp.
Churchill Twp.
Cobalt T.
Coleman Twp.
Dymond Twp.
Eby Twp.
Englehart T.
Eventurel Twp.
Fawcett Twp.
Firstbrook Twp.

Gauthier I.D.
(incl. Dobie P.O.)
Gillies Limit Twp.
Grenfell Twp.
Haileybury T.
Harley Twp.
Harris Twp.
Haultain Twp.
Henwood Twp.
Hudson Twp.
Ingram Twp.
James Twp.
(incl. Elk
Lake P.O.)
Katrine Twp.
Kerns Twp.
Kingham I.D.
(Cooke & Barnet Twp.)
Larder Lake Twp.
(incl. Larder Lake P.O. &
Hearst and
McVittie Twp.)
Lawson Twp.
Lebel Twp.
Lorrain N. Twp.
Lorrain S. Twp.
MacMurchy Twp.
McElroy Twp.
McFadden Twp.

McGarry I.D. (incl.
Virginiatown P.O.).
Maisonville Twp.
Marquis Twp.
Marter Twp.
Mickle Twp.
Milner Twp.
Morrisette Twp.
Mulligan Twp.
New Liskeard T.
Nicol Twp.
Ossian Twp.
Otto Twp.
Pacaud Twp.
Pense Twp.
Playfair Twp.
Ratray Twp.
Roadhouse Twp.
Robillard Twp.
Savard Twp.
Sharpe Twp.
Teck Twp. (including
Kirkland Lake P.O. &
Swastika P.O.)
Thornloe V.
Truax Twp.
Tudhope Twp.
Tyrrell Twp.
Willett Twp.

Board of Health has thirteen members, including the Ontario Government representative.¹ The Secretary is the Clerk-Treasurer for Teck Township, the most populous municipality served. The chief executive officer is the Medical Officer of Health.

As well as at Kirkland Lake, the Unit maintains offices in Englehart where one nurse and the chief sanitary inspector work, and there is a nursing office in New Liskeard with four nurses² and a sanitary inspector.

Abbreviated Financial Statement for the Calendar Year 1962³

Revenue

Province of Ontario	\$ 55,981.89
Member Municipalities	37,568.88
National Health Grants	23,396.20
Sundry	31.64
	<hr/>
	\$116,978.61

Expenditure

Salaries	\$ 89,820.23
Transportation	10,244.64
Fees for professional services	2,798.00
Maintenance, supplies and equipment	12,350.76
Miscellaneous (insurance, Board of Health, audit, pensions, conventions, etc.)	4,557.49
	<hr/>
	\$119,771.12

Deficit \$ 2,792.51

¹1962 Board of Health

Mr. R. J. McBean, Chairman, councillor Twp. of Teck representing Twp. of Teck.
Mr. G. J. McCrank, reeve, Twp. of Teck representing Twp. of Teck.
Mrs. G. P. Valentine, reeve, Twp. Larder Lake representing Twp. of Teck Larder Lake.
Mr. V. Slater, reeve, Twp. McGarry representing Twp. of Teck McGarry.
Mr. George Geoffroy, reeve, Twp. Playfair representing Twp. of Teck Playfair, and improvement Districts of Kingham & Gauthier.

Mr. J. L. Taylor, mayor, Town of New Liskeard representing Twp. New Liskeard.
Dr. W. C. Arnold, councillor, Town of Haileybury representing Twp. of Haileybury.
Mrs. F. R. Purdy, councillor, Town of Cobalt, representing Twp. of Cobalt.
Mr. Thos. Mulholland, councillor, Twp. of Coleman, representing Twps. of Coleman & Bucke.
Mr. L. H. Tucker, reeve, Twp. of Harris, representing Twps. of Harris, Dymond, Harley and Village of Thornloe.

Mr. M. G. Giles, reeve, Twp. of James, representing Twps. of James, Kern, Hudson and Armstrong.

Mr. Ron Ellis, councillor, Twp. of Englehart, representing Towns of Englehart and Charlton, Twps. of Evanturel and Chamberlain.

Mr. L. Belanger, Government representative Earlton.

Secretary—Mr. J. W. McBain.

Medical Officer of Health—E. R. Harris, M.D., D.P.H.

²One nurse from this office works at Elk Lake.

³As in the Annual Report of the Board of Health for 1962.

Classification	Staff ¹		
	Full-time	Part-time	Total
Medical Officer of Health and Director ²	1		1
Supervisor, Public Health Nursing	1		1
Qualified Public Health Nurses	11	2	13
Chief Sanitary Inspector	1		1
Qualified Sanitary Inspectors	3		3
Secretarial and Clerical Staff	5		5
	—	—	—
Total	22	2	24
	—	—	—

There seems to be no particular difficulty in obtaining sufficient public health nursing staff. The authors were impressed by the breadth of experience and training of the available staff. The pay scale is similar to the better pay scales throughout the Province.³

At the moment there is one sanitarian over the base line, that is, a total of four. The fourth was obtained by sponsoring a local man to take the Ryerson Institute course. However, they have found that after a short time many of the younger men tend to go south where living conditions and pay scales are somewhat better. Living costs are less in the north but the pay scale is slightly lower.⁴

Programmes

COMMUNICABLE DISEASE CONTROL

General

Reporting in general is incomplete but the major diseases are well reported. There were 50 cases of infectious hepatitis and one death in the area in 1962. A sharp increase also occurred in German measles and several pregnant women received gamma globulin. Rabies was found in a few farm animals and wild animals. Several people received Semple vaccine preventive treatment. Measles, chickenpox, mumps, scarlet fever, and whooping cough were also more prevalent in 1962 than in 1961.

Tuberculosis Control

The Ontario Department of Health provides and pays for tuberculosis examinations. A miniature unit has been provided by the Province and, in addition, the Unit has its own larger X-ray machine purchased by the Lion's Club. Anyone coming in will be examined whether referred by a doctor or not. A 14 x 17 film is done on those where there is any suggestive history and a miniature film is done on the remainder. Monthly tuberculosis clinics are held in the hospitals at New Liskeard, Haileybury, and Englehart. These are conducted by the Medical Officer of Health who does the physical examinations. X-rays are paid for through the Christmas Seal campaign of the Timiskaming District

¹As of the end of 1962.

²The Medical Officer of Health and Director is a certificated specialist in public health of the Royal College of Physicians and Surgeons of Canada.

³As of October 15, 1962, the salary range was \$4,000.00-\$4,800.00, with an annual increment of \$150.00. For a nursing supervisor it was \$5,050.00-\$5,850.00 with an annual increment of \$180.00.

⁴As of October 15, 1962, the salary range was \$4,000.00-\$4,800.00 with an annual increment of \$150.00. For a chief sanitary inspector it was \$4,250.00-\$5,250.00 with an annual increment of \$150.00.

Tuberculosis Association.¹ In addition, volunteers from this Association assist in conducting the clinic. Since there is no longer a sanatorium in the area, patients are scattered through the sanatoria at Weston (Toronto), Hamilton, and Sudbury.

A tuberculin testing programme is carried out in the area schools with the aim of testing each pupil every three or four years. It is preferred to cover an entire school at one time rather than to test only one grade in all schools. All those who are tuberculin-positive receive a chest film. In addition, a survey conducted through the provincial Department of Health through its travelling service is conducted every four years. This consists of either a miniature X-ray film of the chest in all those over forty years of age or a tuberculin test in all those under forty years with subsequent X-ray of those who are found to be positive. This is a voluntary programme to which any resident in the area may come.

Tuberculosis patients and contacts are followed up as are patients on chemotherapy. Many private physicians ask the Health Unit to arrange follow up of patients and contacts as well as sanatorium admissions. The Province pays for drugs for patients who have left sanatorium following discharge, and these are dispensed through the Health Unit. These must be given by the patient's own doctor where an injection is required or, in the case of Teck Township, by the Victorian Order of Nurses, at his request. The Health Unit staff do not give injections. In the case of follow up elsewhere in the Unit area, the people go to the monthly clinics just described.

Venereal Disease Control

In the field of venereal diseases, the programme is largely that of following up contacts and those who are delinquent in taking treatment. These diseases are reported direct to the Province, and not through the Medical Officer of Health and, therefore, there is some difficulty in obtaining accurate data on the actual incidence. It is also suspected that a proportion of cases are probably not reported at all.

Immunization

An active immunization programme is carried on in the area, particularly for pre-school and school-age children. The procedure is to give smallpox vaccine and the quadruple antigen.² It is provided at certain child health conferences in the urban centres.³ In the purely rural areas, which are some distance from these routine child conferences, the public health nurses do immunization in the homes. Reinforcing doses are given routinely under the school programme to Grade VIII.⁴ This consists of smallpox re-vaccination and the triad antigen.⁵ Adults may come to the child health clinics and obtain immunization with smallpox vaccine, Salk vaccine, and tetanus toxoid. For other antigens it is suggested that they see the family doctors.

¹See p. 293.

²DPT Polio—diphtheria toxoid, pertussis vaccine, tetanus toxoid, and Salk polio vaccine.

³See p. 273. Immunization is offered weekly in Kirkland Lake, in two series a year at New Liskeard, and in one series a year at Virginiatown, Larder Lake, North Cobalt, Cobalt, and Haileybury.

⁴See p. 275.

⁵DT polio—diphtheria toxoid, tetanus toxoid, Salk polio vaccine.

In addition, a special smallpox vaccination programme is carried out for the hospital staffs of the Kirkland Lake, New Liskeard, and Haileybury Hospitals. The Salk vaccine programme was carried out in the area and the first of the Sabin programmes was successfully completed in 1962, with 81.5 per cent of children and 23.7 per cent of adults being immunized.

SANITATION

Water Supplies

There are nine municipally operated public water supply systems in the area:

	<i>Source</i>	<i>Treatment</i>
Kirkland Lake	Gull Lake	chlorinated and fluoridated
Swastika	Blanche River	chlorinated and fluoridated
Larder Lake	well	none
Virginiatown (McGarry)	Larder Lake	chlorinated
Englehart	drilled wells	none
New Liskeard	drilled wells	none
Haileybury	Lake Timiskaming	filtered and chlorinated
Cobalt	Lake Sasaganaga	chlorinated
Ramore	well	none

The role of the Health Unit is to do routine inspections to assure the absence of health hazards. In addition, there are some 31 privately operated public water supplies in the area.¹ The public supplies are sampled regularly.² Private supplies are tested only on request.³

Sewage Disposal

Sewage disposal in the towns is by large municipal septic tanks except where there is a lagoon plant. Recently, an area by-law has been passed requiring people wishing to instal septic tanks to meet minimum requirements about size, location, etc. The control of septic tanks is sometimes a problem because people are not always interested in having enough capacity for the tank and the proper number of tiles. They have endeavoured to extend this from the organized municipalities into unorganized areas as well, but this last has proven more difficult to control except in new cottage sub-divisions.⁴ A number of improperly installed systems, installed before the law was enforced, remain in operation and present problems from time to time. Plumbing inspections are a responsibility of individual municipalities, not of the Health Unit.

Milk Supplies

There are approximately 68 raw milk shippers in the area.⁵ There is close co-operation with the Department of Agriculture Inspector⁶ who covers a much wider district. There are five dairy plants in the area. In 1960, one of these

¹ Serving more than one family.

² Two hundred and seventy tests in 1962.

³ Four hundred and eighty-six tests in 1962.

⁴ An amendment to the regulations on septic tanks in unorganized territory is expected to be a big help.

⁵ Four hundred and eight visits to producers in 1962.

⁶ A representative of the Milk Industry Board.

changed its method of collecting raw milk to that of bulk haulage. Therefore, the sanitary inspector has to visit the farms at the time of collection to secure raw milk samples from the producers' storage tanks. For the other four dairy plants, raw samples are taken from the cans when they arrive at the plant. The pasteurized milk is sampled at the plant twice a month, and oftener if indicated.¹ A thorough inspection of the dairy plants is done twice a year with follow up as indicated. Tests are sent to the Provincial Laboratory at Timmins.² During the past few years there has been a marked improvement in the quality of milk being delivered to the dairies.

Slaughterhouses and Meat Inspection

Most meat sold for human consumption in the area comes from the large outside packing houses³ and, therefore, it is either federally or provincially inspected. There are eight small slaughterhouses in the area. These, from 1960 on, have been issued permits if, following inspection, their sanitary conditions were found to be satisfactory.⁴ No attempt was made to inspect carcasses of meat from these plants.⁵ The plants are checked once every two months. In addition, there are two small farmers' markets in Kirkland Lake and in Cobalt which are chiefly meat markets. These are, again, checked in terms of their cleanliness but not in terms of the standard of the meat itself. All of these local sources provide only a small proportion of the meat distributed and used in the area.

Food Outlets

These are checked for general sanitary conditions on a yearly basis when they are licensed. Eleven bakeries and seven other establishments are so checked. Other visits are made only when a complaint has been lodged with the Unit. There are two food lockers in the area which are inspected twice a year only as to the general sanitation.

There are seven plants producing soft drinks locally. These are checked monthly. They have contracts with major firms and, thus, are under a measure of outside control as well. There is one separate ice cream plant where samples are taken once or twice a month. Thereafter, visits may be made on the basis of complaints. There are a few food-vending installations in the area but so far these have produced no complaints and as yet are regularly checked. However, it is envisioned that if these grow in numbers it will be necessary to institute some type of inspection system.

Restaurants, hotels, and eating places are inspected thoroughly twice a year and test swabs are taken of utensils, etc., twice a month. Visits are made more often if indicated.⁶ These are sent to the Provincial Laboratory in Timmins. A yearly X-ray is required for all food handlers. When they are visiting the

¹Three hundred and sixty-eight visits to distributors made in 1962.

²This presents certain problems in setting a schedule for obtaining samples and forwarding them so that prompt reports are received. Sometimes a lag of a week or more results. There is some feeling on the part of the sanitary inspection staff that a small milk control laboratory in the Unit would be useful.

³Over 90 per cent is estimated to come from these sources.

⁴Sixty-seven inspections in 1962.

⁵Until 1957 there was a public health veterinarian on the staff of the unit and some local meat inspection was carried on. Since that time this has not been possible.

⁶One hundred and fifty-eight establishments and 1,306 inspections in 1962.

restaurants and hotel dining rooms the inspectors do some teaching to the proprietors and to food handlers. The problem of eating places in the area is that most of the buildings are old, except for a few restaurants in the larger centres. Thus, the problem is to keep such establishments up to a basic hygienic standard. As well, there is the problem of the education of food handlers. Courses were given some six to seven years ago but they were not widely attended nor accepted and, indeed, because of the rapid turnover, probably had limited impact. It is felt that some improvement is needed in the smaller restaurants, but that this will be difficult to obtain because of the cost involved in improving the general premises in order to enable them to reach basic standards, and also because of the problem of employing staff who are sufficiently interested and educable in proper food handling techniques.

On request, the eating and washing facilities in hospitals are checked yearly.

Coin Laundries

So far there are only a few, which present no problems. They are inspected from time to time.

School Sanitation

Schools are checked once a year for their general sanitary arrangements and re-checked if indicated. Except for a few of the remaining small rural schools, the sanitary arrangements in the schools have vastly improved in recent years and are generally satisfactory. It is difficult for the small rural schools to provide adequate sanitary arrangements. Pressure is being placed by the Health Unit to try to assist the education authorities and others in furthering the school consolidation programme.

Swimming Pools and Areas

The open public swimming pools are sampled three to four times in the season for the use of chlorine, etc. A filtration plant and chlorination equipment were recently installed in the swimming pool in Englehart. This has greatly improved the safety of this particular pool. Swimming beaches are checked two to three times a week during the summer. Private pools are only checked on request. These have not presented any great problem so far.

Camps and Resorts

Summer camps and resorts are inspected annually for the provincial licensing requirement, and once or twice more if they operate throughout the entire summer. This is a general sanitary inspection of water, sewage, and kitchen facilities, etc. These present no particular problems.

Garbage

In urban centres regular collections take place. Garbage is handled through the municipal works departments. This is not the responsibility of the Health Unit. However, the open dumps are visited regularly to be sure that sanitary conditions prevail.

Pest Control

Pest control is only carried out on specific complaint. It has not presented a great problem.

Housing

Housing inspection is carried out only at the request of the municipal clerks, the public health nurses, and others, where a possible health hazard is involved. The question is usually one of condemning a vacant house. Much of the housing in the Timiskaming District is of a substandard nature, but because of the economic situation in the area and the low educational skill and wage levels, it is difficult to do much about this except in a gradual way. In unorganized territory, new cottage areas are checked concerning drainage and water supply, etc. Most of the cottage areas being built now are in the unorganized areas.

Air Pollution

This is no great problem in the area. The only sources of air pollution are the extracting processes at some of the mines. The only major one near a municipality is at the Lakeshore Mines in Kirkland Lake, where a roaster is used to extract the gold. It so far has not proven a problem, but inspection could be carried out if deemed necessary.

General Comment

One of the sources of some difficulty is that some of the legislation on environmental sanitation, especially concerning inspection, is general in nature. This has resulted in somewhat different interpretation and enforcement of the regulations from health unit to health unit. It is felt that the legislation and regulations need to be more precisely delineated, so that the inspectors will have definite legal bases for their programmes. At present, much of the work is done by tactful encouragement and pressure, often in the absence of precise legal grounds.

MATERNAL AND CHILD HEALTH

Prenatal Programme

During 1961, three series of prenatal classes were conducted in Kirkland Lake, two at New Liskeard, and one in Haileybury. The number of series varies from year to year depending upon the need and demand.¹ A series consists of eight classes. The teaching is bilingual. Most of the family physicians send in lists of their prenatal patients to the Health Unit and, in general, the family physicians seem to value the prenatal classes very much. The facilities used were the Young Men's Christian Association in Kirkland Lake, the New Liskeard and District Hospital in New Liskeard, the Misericordia Hospital in Haileybury.

All prenatal physical examinations are conducted by the patients' own family physicians. However, the public health nurses visit the homes of the patients whose names are sent in for educational and follow-up purposes. This is done on a once-a-month basis for the first seven months and every two weeks thereafter.² One name in six in Teck Township is referred to the Victorian Order of Nurses staff nurse. In the other areas the work is carried out entirely by the public health nurses. There were 1,167 resident live births and 11 stillbirths in 1962.

¹In 1962, two series only were held.

²Approximately 45 per cent of mothers (525) received one or more prenatal visits in 1962 (includes 79 V.O.N. cases in Teck Township). This figure is obtained by relating the number of new prenatal home visits to the number of resident live births in the year as was done by G. K. Martin and K. B. Ladd, "Maternal and Child Health Services, Ontario, 1958". *Canadian Journal of Public Health*, March 1961, p. 112. This method of calculation is not wholly accurate but gives a useful indication.

Post-natal Programme

In the four area hospitals, visits are made by the public health nurses on Mondays and Thursdays to all post-partum mothers.¹ As soon as possible after discharge from hospital, the nurses endeavour to visit each baby in the home because it is felt that during this period they can be of maximum assistance.² The mothers are also given post-natal care and are urged to go to their physician for a post-natal check-up.³ Follow-up visits after the initial visit are made as indicated by need or request. For those patients seen for post-natal care by the Victorian Order of Nurses in Teck Township, visits are made during the initial six weeks and then the patients are turned over to the public health nurses for any subsequent home visiting. This programme is welcomed by all but one or two doctors in the entire District. Even some wealthier private patients, as well as those in the lower income categories, are encouraged to use the service. A few of the nurses felt that the post-natal visit, other than the one in the hospital, should be selective, and that a routine visit should not be made to the home also. Others felt that the need for visits was not always clear until the mother was in her own home and was actually coping directly with the problems of infant care.

A phenyl-ketoniauria testing programme on all newborns was begun in September 1962. No positive cases were found by the end of the year.

Well-baby and Child Health Conferences

Conferences are held in Kirkland Lake one afternoon a week. The mothers are interviewed by the public health nurses and their babies are checked. Only if immunization is to be done are the mother and baby referred to the Medical Officer of Health.⁴ No other medical supervision is given at these conferences.

Conferences are also held once a month in Virginiatown, Larder Lake, North Cobalt, and Cobalt, and twice a month in New Liskeard and Haileybury. Immunization facilities are provided at specific intervals at these conferences. In the outlying areas immunization is done by the public health nurses on their home visits.

Attendance at the clinics is high. There are twelve conferences held in the area during each month except during the summer months. The number of individual cases of all ages attending in 1962 was 1,031 (not including solely immunization clinic visits). Also indicative of the high degree of acceptance of the programme is the fact that several doctors encourage their patients to attend these well-baby conferences routinely.⁵ Except for immunization purposes, attendance drops off sharply for children over 12 months of age.

¹Except in one or two instances where the family doctor has indicated he does not wish it.

²In 1962, approximately 64 per cent of newborn babies under one month of age (749) were visited by the public health nurses. If V.O.N. visits (65) are added, the total is approximately 70 per cent. It should be added that almost all infants are visited at least once in the first year of life.

³Some doctors do not carry out post-natal examinations routinely and on occasion the practice of urging patients to seek one may create some friction with such doctors.

⁴See p. 268, for antigens given.

⁵There were 1,167 resident live births in 1962. The number of individual attenders would include many babies born in 1961 and exclude those born at the end of 1962. The actual percentage of attenders under one year of age is unknown but a possible rate of about 70-75 per cent of eligible infants may be estimated, if one assumes that only a relatively few children over one year are brought.

At three months of age a letter goes out in the Teck Township area to urge the new parents to get their children immunized. In outlying districts where no convenient conferences are held, the public health nurses try to visit the children of three months, six months, and one year of age. More frequent visits are made where indicated.

General Comments on Maternal and Infant Health

The co-operation between the doctors and public health nurses is generally good. A few of the doctors have expressed concern that public health nurses are apt to be overzealous, in their view, in referring patients to them for minor problems of diet, adverse family conditions, etc. Most of the doctors accept the immunization programme readily as a valuable aid to them, but a few regard it as interference with their prerogatives. One doctor in particular will have nothing to do with the Health Unit services. His maternity patients are not visited by the public health nurses. Only if they come voluntarily to any of the conferences are they seen.

On the other hand, some of the nursing and non-medical people in the area expressed concern over the varying standards of obstetrical care available in the area. Some doctors, it was indicated, show little interest in prenatal and especially post-natal maternal care. The view was expressed that a consultant obstetrician was badly needed in the area. It was felt that not only could he cope with problem cases but that his presence would have a salutary effect on the standard of prenatal and post-natal care provided. It is understood that though some of the physicians would welcome such a colleague, others would regard him with less warmth and would use his services rarely at most.

Infant Boarding Homes and Boarding Homes for Mothers

In the Province of Ontario, the Maternity Boarding Homes Act requires that anyone boarding a child under the age of three years for money must obtain permission from the Medical Officer of Health. The public health nurses visit the homes before licences are granted. The homes are supervised monthly thereafter and there is close co-operation between the Children's Aid Society and the Health Unit. The Unit staff feel that licensing should be made a responsibility of the Children's Aid Society.

Pre-school Child Health Programme

The Well-baby and Child Health Conferences, already mentioned, are available to older pre-school children but there tends to be a considerable falling off in attendance once the child reaches one year of age. The nurses will visit homes as requested by the doctors or families or as they themselves note the need.

At the time of the pre-school spring "round-up", letters are sent out requesting parents to have their family doctors examine all children who will be starting school. If this is not done, they are again urged to have it done when the child first comes to school. The Health Unit pays for this examination and about 70 per cent usually are examined in this way.¹ For the remainder, the public health nurses do a general inspection once they reach school and those children with defects are referred to the family physician. These are subsequently followed up to be sure that something is done. In co-operation with the school

¹In 1962, 746 pre-school examinations were carried out by family physicians.

authorities in the larger communities, the nurses also interview the mothers of the children starting school at the time of the pre-school registration. This has been found to be satisfactory and beneficial to the child, parents, and the service in the schools.

SCHOOL HEALTH SERVICE¹

Primary School Service

In all grades a rapid classroom inspection is carried out by the public health nurses shortly after the opening of school in September to detect any communicable diseases, head lice, etc. Likewise, a rapid inspection is done after the Christmas and Easter vacations at the discretion of the public health nurse.

Early in the school year a meeting is held in each school between the principal, the staff, and the public health nurse to discuss the school health programme for the year and to obtain any comments and suggestions. The Medical Officer of Health and the principals meet every few years as well.

The nurses carry out general inspections of all new pupils in the schools, such as those who have transferred from a school outside the Health Unit area, unless an inspection has been recorded within the present school term. All pupils in Grade VIII have a nurse inspection, and annually all pupils with uncorrected defects are checked. Otherwise, only children referred by the teacher are checked. This is based on a conference between the teacher and the public health nurse. As well, children may be referred by parents. Annual nurse-classroom conferences are held on pupils in Grades II to VII inclusive, on an annual basis. If the pre-school examination has not been completed by Christmas time in the first year of attendance, then the nurse does a health inspection and refers children with health problems. Children are referred to the family doctor for medical inspections whenever the public health nurse or teacher feels that this is desirable.

The Health Unit pays the physician for any school examinations carried out. In 1962, there were 405 medical examinations carried out on elementary school children.

Vision testing is carried out by the nurses in Grade I (usually done after Christmas so the child will have had a chance to adjust to the classroom), in Grade IV, Grade VI and Grade VIII.² In addition, tests are done on individual children brought to the attention of the public health nurse by the parent or the teacher. All children known to have defective vision are checked annually as are all new admissions to a school. Children with defects are referred to their family doctors.

Records are kept alphabetically and according to classroom. This includes all visits, immunization records, pre-school medical cards and any subsequent findings. Pupils with skin infections are readmitted either through the Health Unit office by the Medical Officer of Health or the public health nurse. In rural schools they are readmitted by the teacher, when the area's notification of communicable diseases is carried out, using special forms left with the teacher for notification to the Health Unit. The teacher may also reverse the charge of a telephone call to report a communicable disease.

¹In 1962, there were 69 elementary schools with 10,420 pupils and 5 secondary schools with 2,874 pupils in the Health Unit area.

²Testing is done with the illiterate Snellen chart in Grades I and II and thereafter the projecto-chart is used.

Tuberculin testing is done using the Heaf Test and an attempt is made to do an entire school every few years. All positive reactors are X-rayed at the chest clinics and a thorough investigation is carried out.

Gross hearing testing is carried out in Grade I and thereafter as indicated. There is no audiometric programme.

Secondary School Service

Children taking part in physical sports in the high school are referred for medical examination before the competitive sports begin. The costs are paid to the family doctors at the rate of \$2.00 for each examination. On entering Grade IX all students with uncorrected defects may be referred for a medical examination and are interviewed. All students who have not had a medical in Grade I and no subsequent record of medical examination are referred for one. In addition, the teacher may refer, through the nurse to the family,¹ any student in high school whom she feels requires a medical examination.

Vision tests are done on any student brought to the attention of the nurse by parents or teachers or other interested persons. Annually, all students who have defective vision are brought to the attention of the nurse. In three of the communities, Englehart, Haileybury, and Cobalt, routine vision testing is done on all Grade XI students. All new admissions to the school from outside the Health Unit are also given routine vision tests.

One of the most important services has been that of counselling, and the students in the high school are frequently referred by teachers to the public health nurse for counselling. This is done on a straight teacher-referral or self-referral basis.² In turn, problems which the nurses feel they are inadequate to handle may be referred to the Children's Aid Society which has a staff of several trained social workers. They are the only trained social workers in the entire district and frequently are heavily loaded with work in relation to their regular duties. It is felt by many that there is a need for a definite child guidance programme, particularly in the high schools, and some measure for psychiatric-psychological counselling, diagnosis, and on-going treatment of those requiring it. They feel that these problems are among the most serious which they are facing.

General Comments

The opinion was expressed that the vision tests could well be carried out by someone other than the nurses, if such people were available. Some of the nurses felt that some of the teachers were apt to turn over to them a good deal of minor first-aid work which, in their view, could be carried out by the teachers themselves.

It has been found that, increasingly, pupils are being referred to the public health nurse because of emotional and psychological problems. Although they can handle most of the minor ones, it is difficult to do so for those that are more serious but not sufficiently serious to warrant referral to a mental hospital. The guidance teachers are essentially in the vocational counselling field and feel inadequate to handle these problems. The public health nurses, on the other

¹In 1962, 152 secondary school students received examinations as a result of referrals for these various reasons.

²Seven hundred and ninety-six secondary school students were interviewed in 1962.

hand, feel that beyond the rather minor types of problem they too are inadequate to handle them. Both school authorities and the public health nurses feel very strongly that there is the need for psychiatric and psychological services on a regular basis. At present the only psychiatric service available is by referral to the Ontario Hospital in North Bay.

There are opportunity classes in the public schools but so far the separate schools do not have these facilities. This means that sometimes pupils can be transferred by consent from the separate to a public school, but in many instances they remain in the separate school and continue to present problems to the school and fail to develop adequately themselves.

There is a retarded children's school in Kirkland Lake which receives some local and provincial grants. This was started as a private venture for children who are below the intelligence level acceptable to the primary schools.¹

Some of the nurses expressed the view that there was still too much routine work being done by them in the school programme, and that the teachers could do many of the straightforward things, such as weighing and measuring. On the other hand, several of the school authorities felt that they would like to have the nurses there full time to do first aid.

Another problem as seen by the school authorities is a need for dental services. There is a tremendous backlog of dental caries and bad teeth in the far northern area. At one time the Red Cross and the Health Unit provided a dentist in one school for all area students. This arrangement was abandoned about ten years ago. Therefore, the only actual dental supervision is by a public health nurse who does a rapid survey only. Needy cases in children are referred to service clubs to pay for such care as they may require. Those under the supervision of the Children's Aid Society are paid for by the Municipal Departments of Public Welfare. The problem, however, is that the Municipal Welfare Departments will only pay for extractions and not for general corrective work. At present there is some further difficulty in getting dental care because there are only eleven dentists in the area and these are frequently booked well ahead. The school authorities and nurses feel that some type of organized programme would be desirable.

Children with limited vision also present a problem. They are referred to their own doctor or the eye, ear, nose and throat specialist in Kirkland Lake who has a waiting list of about six months for an appointment. Another problem is how to obtain glasses for them when required. The service clubs help and the Children's Aid can get welfare assistance for those children under its care but even this help is sometimes difficult to obtain.

The school authorities are happy with the immunization programme. They have found the sanitary inspectors' reports particularly helpful with the rural school boards in getting improvements in facilities, wells, a new roof, new floor, and modern sanitation, etc.

In the outlying areas the public health nurses visit the small schools only once a month in some cases. The education authorities wonder if this is really sufficient.

¹No specific data were obtained on this programme.

HEALTH EDUCATION

Health education is done on a personal contact basis by all members of the staff as they carry out their duties. They use the available literature from the provincial Department of Health. There is good co-operation with the newspapers and other mass media in the area.

ACCIDENT CONTROL

This is largely a follow-up on poison control reports from the Kirkland Lake and District Hospital Poison Control Centre. When they are visiting the homes the public health nurses and sanitary inspectors do check up on obvious hazards and make recommendations for removing them. The mines have their own safety programmes.

PUBLIC HEALTH NURSING AND HOME CARE

A major need in the area, as seen by the Health Unit staff, is for comprehensive facilities and services for the chronically ill and the aged. The only available bedside nursing care is that of the Victorian Order of Nurses in Teck Township. It has been found necessary by the Unit to provide a limited bedside service of an emergency type, such as giving injections and changing dressings, in areas without service by the Victorian Order of Nurses.¹ At the moment the Unit does not have sufficient staff and funds to provide more extensive visiting home nursing care for those discharged from hospitals, and for the chronically ill. Homemaker services are also felt by the Health Unit staff to be needed. One suggestion has been to use registered nursing assistants under supervision.² Cases referred to the new Mental Health Clinic and discharged from the Ontario Hospital in North Bay are followed in the home by the public health nurses in co-operation with family doctors and others concerned.

CANCER CONTROL³

The Medical Officer of Health is voluntary chairman for the Ontario Cancer Foundation Diagnostic Clinics in the Timiskaming District. These clinics are held on alternative months in Kirkland Lake and New Liskeard, with the assistance of volunteers from the local branches of the Canadian Cancer Society in the Kirkland Lake and tri-town⁴ areas. Cases on referral are seen for diagnosis, and follow-ups are made on all patients returning from treatment at the Princess Margaret Hospital in Toronto.⁵ The public health nurses visit cancer patients in their homes to give limited nursing care and to obtain socio-economic background information.⁶ The clinics have a volunteer staff of four doctors from the local medical societies, including the Medical Officer of Health. The Unit public health nurses serve in the clinics.

¹Two hundred and forty-five bedside-care public health nursing visits were made in 1962, as well as visits to six cancer patients and 70 orthopaedic patients. Twenty mental health visits were made.

²See p. 280.

³See also p. 295.

⁴New Liskeard, Haileybury and Cobalt.

⁵Total attendance in 1962 was 149 at 10 clinics.

⁶Forty-nine such home visits to six cancer patients were made in 1962.

All reports go to the family doctor and in turn to the Princess Margaret Hospital in Toronto. The public health nurses also make limited visits to two of the local hospitals on cancer patients. Most appointments at the Princess Margaret Hospital are booked through the Unit. If patients require transportation this is arranged and the Ontario Cancer Foundation will pay for it. The local Cancer Societies upgrade the fare to a first class one when desirable.

MENTAL HEALTH

In the past, from time to time, clinics were sent from the Ontario Hospital at North Bay, which is the nearest Ontario Hospital.¹ There has been interest in establishing a regular monthly clinic and the first of these was held in November 1962, in Kirkland Lake. Staff is supplied from the Ontario Hospital at North Bay. The clinic is conducted with the support of the local doctors and the Health Unit. The cases are obtained on medical referral.² Additional information is gathered by home visits by the public health nurses. Cases discharged from the Ontario Hospital in North Bay, if referred, and patients referred from the clinics are followed by the public health nurses in co-operation with the family doctors and any concerned agency, such as the schools and the Children's Aid Society.³ Refresher courses are offered by the Ontario Hospital for the public health nursing staff, and its social worker offers advice and guidance regularly.

EMERGENCY MEASURES ORGANIZATION

The Medical Officer of Health is the Medical Director for the District but, because of uncertainty about this programme at senior levels of government, the local programme remains inactive.

LIAISON WITH OTHER HEALTH SERVICES

The Medical Officer of Health is not a member of any of the hospital boards but is a member of the consulting staff of the Kirkland Lake and District Hospital. He is consulted on communicable disease problems, and is on call for the other hospitals in the event of any problem which they wish to refer to him. None of the hospitals has an active infections committee. The Medical Officer of Health is an active member of the Kirkland Lake and District Medical Society and has good relations with the doctors in the area.⁴

Relations with the provincial Department of Public Welfare staff and local welfare officers are good. Relations with the Victorian Order of Nurses in Teck Township are close.⁵ The Medical Officer of Health is an active member of the board of the local branch of the Ontario Tuberculosis Association.⁶ There is close liaison with the local branches of the Canadian Cancer Society.⁷ There is close

¹ The last was in 1955.

² Eight cases to the end of 1962.

³ In 1962, twenty home visits were made.

⁴ Only one or two show some reluctance in co-operating with the Unit's programme.

⁵ See pp. 290-291.

⁶ See p. 293.

⁷ See p. 295.

co-operation with the orthopaedic clinics operated by the Ontario Society for Crippled Children and with the Society's district nurse.¹ The Unit nurses keep close contact with her and visit homes on request.² There is also good co-operation with the staff and clinics of the Rehabilitation Foundation for the Disabled³ and with the local work of the Canadian National Institute for the Blind.⁴ There is good co-operation with the Children's Aid Society.⁵ At their request, homes are visited and health matters are followed up. In turn, referrals about social problems are made to the Society.

Local service clubs provide glasses and some dental care for needy families.⁶ The Unit keeps in close touch with the welfare committees of these clubs.

GENERAL COMMENTS

Dental health care, not only for low-income families but for all families in the District, is considered to be a major health problem. There is an over-all shortage of dentists, especially in the southern section.⁷

There is also felt to be a growing need for more adequate services and facilities for the elderly and the chronically ill, including visiting nursing, homemaker services, physiotherapy, and varied kinds of accommodation. The Unit would like to provide more visiting bedside nursing care, possibly using registered nursing assistants under supervision, but is hampered for financial reasons in doing so. Rural areas are regarded as having particular needs for these services but tend to be reluctant to provide the required funds.

Public Health Services in Municipalities Outside the Health Unit Area

Five organized townships, including two villages and four unorganized townships, and one town, have not voted to enter the Health Unit area.⁸ They contained a population of approximately 3,274 people at the end of 1962 and are served by part-time medical officers of health who are local practising physicians. They are paid modest honoraria⁹ based on the population served and carry out only the basic statutory responsibilities. In an emergency they could turn to the Health Unit staff for assistance on a specially arranged basis.

To the observer, the contrast in services between the Unit area and the outside areas is striking indeed. The former is covered by an extensive, full-time programme whereas the latter have almost no services. It would seem most desirable for the outside communities to be included in the Health Unit.

¹Two clinics with 79 cases attending in 1962. See also p. 292.

²Seventy cases visited in 1962.

³One clinic with 43 cases attending in 1962. See also p. 292.

⁴See p. 294.

⁵See p. 296.

⁶See p. 289.

⁷See p. 283.

⁸Brethour township, Casey township, Dack township, Hilliard township (including Thornloe village), Matachewan township (including Matachewan village and the unorganized townships of Cairo, Yarrow, Powell, and Kimberley), and the town of Latchford. At the end of 1962, Matachewan township reverted to unorganized territory status.

⁹These are in the range of \$25.00 to \$100.00, depending on the population served.

PHYSICIANS

General

There are 34 physicians in the District, seven of whom are in full-time specialist, laboratory, or administrative work.¹ Several others, including one certificated general surgeon, devote most of their time to surgery. Group practice is well established in Kirkland Lake and Englehart, whereas elsewhere the pattern is one of solo practice. Most of the practitioners do their own obstetrical work and a varying amount of gynaecological and general surgery. In one of the groups, major surgery is largely done by the only certificated surgeon in the area and by the more senior members who have had a good deal of experience. Most eye, ear, nose and throat problems are referred to the specialist in Kirkland Lake. Except for emergency care, the practice is to refer the more rare surgical problems, such as neurosurgery, spinal surgery, cardiac surgery, and some orthopaedic surgery, to specialists in Toronto.² Cancer cases requiring extensive surgery, and all requiring radiotherapy, are referred to specialists and to the Princess Margaret Hospital in Toronto. Many orthopaedic problems in children are sent to the Hospital for Sick Children in Toronto. Until recently there was a qualified urologist in practice in Kirkland Lake. Now a urologist from North Bay comes up once a month. However, most urological cases tend to be sent to Toronto. Severe psychiatric problems are referred to the Ontario Hospital in North Bay, though some are referred to a private psychiatrist in Sudbury. Tuberculosis patients go chiefly to sanatoria at Weston (Toronto), Sudbury, and Hamilton. The special annual or twice yearly clinics, supported by the Ontario Society for Crippled Children³ and the Rehabilitation Foundation for the Disabled,⁴ are used for referral. The new visiting mental health clinic is an additional service for referral cases.

The two radiologists in Kirkland Lake provide diagnostic X-ray services on a scheduled basis to the four hospitals in the District as well as to a number of hospitals outside the area. The pathologist in Kirkland Lake is director of the laboratory in the local hospital and a qualified biochemist on his staff visits the hospital in Englehart once a week to carry out certain laboratory procedures. The internist is director of the laboratory in the hospital at Haileybury. He also is in charge of the laboratory in the hospital at New Liskeard, only five miles

¹Kirkland Lake—18—includes:

One group of seven.

One group of four (one is a certificated surgeon).

One in solo practice.

One qualified eye, ear, nose, and throat specialist.

Two qualified radiologists.

One qualified pathologist serving as hospital laboratory director.

One doctor at the Ontario Workmen's Compensation Board Miners X-ray Station.

The Medical Officer of Health (a certificated public health specialist).

Larder Lake—1. A certified surgeon recently left.

Virginiatown—1.

New Liskeard—6, two of whom worked together.

Englehart—3, working as a group.

Haileybury—4, including a qualified internist with special training in pathology serving as hospital laboratory director.

Cobalt—1.

²North Bay and Sudbury have qualified specialists in a number of fields but these are sent only a relatively small number of referrals. It is felt that if one must be sent outside, the travel time to Toronto is not much greater.

³See p. 291.

⁴See p. 292.

away. As mentioned elsewhere, local doctors, including the Medical Officer of Health, staff the cancer clinics in the area.¹ The Medical Officer of Health and his staff provide a diagnostic and follow-up chest clinic service.²

Comments

It was felt by many of those interviewed that one of the serious problems was the shortage of qualified specialists, especially in the more common fields of internal medicine, general surgery, obstetrics and gynaecology, and paediatrics. Their absence, or at best extreme scarcity, has meant that the doctors in the District have tended to undertake procedures, especially in surgical fields, which are now regarded in the more populated areas of the Province as requiring specialists. Though some doctors recognize the problem, and would in fact welcome such specialist colleagues, one has the impression that others would be reluctant to alter the present scope of their practices by referring much work to them. It is true that the location and nature of the District has, by and large, not proven attractive to many specialists to date, but not all of the discouragement has come from the physical environment. On the other hand, the doctors in the Kirkland Lake area were among the first to encourage the post-graduate education programme of the university medical faculties, supported by the W. K. Kellogg Foundation and the Ontario Medical Association. Approximately five one-day special refresher clinics on different subjects³ are held each year with staff from the universities, chiefly the University of Toronto. All area doctors are invited as well as others within a reasonable distance. These clinics have been well attended by most of the local practitioners.

In general, relations with the Health Unit are good. Most doctors welcome the prenatal, post-natal, immunization, school, and home visiting services provided.^{4,5} Some minor differences arise on occasion where public health nurses refer people to their doctors for matters which the latter may sometimes feel do not warrant a visit, or where public health nurses urge people to seek a degree of prenatal and post-natal care which not all of the physicians routinely provide. These minor problems seem to be overcome by mutual tact and goodwill. On the other hand, one doctor has almost no co-operative relationships with the Health Unit and a few seem to regard the Unit as the "thin edge of the wedge of state control".

The doctors in the communities with hospitals would be most loath to lose these facilities through some type of area co-ordination which might change the two larger hospitals into base hospitals with the more complex ancillary staff and facilities, and convert the smaller hospitals into medical and chronic units only.

Some concern was expressed over sending materials for laboratory examination to the Provincial Laboratories in Timmins and North Bay when free or low-cost service was required. The two larger hospital laboratories feel they could do many of these but are hampered because of having to charge for their services. Another related complaint was over the time lag before reports came back from the more distant laboratories in some instances.

¹See p. 278.

²See pp. 267-268.

³Topics such as heart disease, cancer, and general surgery, etc.

⁴See p. 268, pp. 272-274 and p. 278.

⁵Two men remarked that they felt the services gave needed care to their patients and enabled them to devote their time to clinical work.

DENTISTS

There are 11 dentists in the area.¹ None are dental specialists. Several are older men who are only partly active. The District has not been able to attract sufficient numbers of younger men to replace those lost by retirement and death. At present the shortage is more acute in the tri-town area.² Waiting lists are long and some dentists have had to restrict themselves to offering full service only to people in their immediate areas. Others are given only emergency care. For example, New Liskeard, Cobalt, and Haileybury, which draw patients from a surrounding population of about 20,000-25,000 people, have only three dentists, one of whom is only partly active. Two dentists died in recent years and no replacements have come to begin practice. Some people go to dentists in nearby parts of Quebec but these areas are also short of dentists. The Ontario Government and Red Cross dental rail cars come to the outlying parts of the District every few years, but these services have had to be curtailed in recent years because of an inability to obtain sufficient dentists to man all of them.

OTHER PROFESSIONAL AND TECHNICAL PERSONNEL

Registered nurses to do hospital nursing are in short supply, especially in Haileybury where the shortage is acute. The picture is better during the winter and worse during the summer. Qualified dietitians, physiotherapists, social workers, and laboratory and X-ray technical personnel are either in very short supply or, in certain instances, are non-existent. Most of the nurses and many of the other personnel are married women whose husbands work in the area. Because unskilled and semi-skilled jobs are more common, the number of families which contain professionally trained people of any kind are relatively few.

HOSPITALS

There are four general hospitals in the District, the Kirkland and District Hospital at Kirkland Lake, the Misericordia Hospital at Haileybury, the New Liskeard and District Hospital at New Liskeard, and the Englehart and District Hospital at Englehart.

Kirkland and District Hospital

This municipally owned public general hospital has a rated bed capacity of 162 beds, including 19 for chronic cases and 29 bassinets.³ The average occupancy rate was 80 to 85 per cent in 1962. Much of the hospital is of recent construction⁴ and is well equipped with operating room, X-ray, laboratory, and other surgical facilities. The medical staff, both active and honorary, number 23. Of these, two are qualified radiologists, one is a qualified general surgeon, one is a qualified pathologist, one a qualified eye, ear, nose, and throat specialist, one is the Medical Officer of Health,⁵ and one the chest physician, at the Compensation Board.⁶

¹Kirkland Lake—7; Virginiatown—1; New Liskeard—2; Cobalt and Haileybury—1 (an office in each).

²New Liskeard, Cobalt, and Haileybury.

³On the average there were 146 general beds, 19 chronic beds, and 28 bassinets reported, as set up by the 1962 Canadian Hospital Directory.

⁴Built in 1926 with additions in 1935, 1939, and 1959.

⁵A certificated specialist of the Royal College of Physicians and Surgeons of Canada in public health.

⁶A qualified urologist comes from North Bay once a month to do surgery.

The hospital administrator is a graduate of the University of Toronto course in hospital administration.

The non-medical full-time staff number 225:¹

registered nurses	70
auxiliary nursing staff	30 to 40 ²
registered laboratory technologists	2 ³
registered X-ray technicians	3 ⁴
and others	110 to 120 ⁵

The hospital is accredited by the Canadian Council on Hospital Accreditation, but some of its staff shortages could jeopardize this standing. Registered nurses are in reasonable supply, except during the summer vacation period, but nurses with additional graduate training in administration, and nursing education, etc., are almost impossible to obtain. Though facilities are available, at the time of the visit the hospital was without a physiotherapist. One subsequently joined the staff in January 1963, but it is uncertain how long she will stay. A qualified dietitian also came at that time. Medical record librarians and medical social workers are almost unobtainable. Registered laboratory and X-ray technical personnel are in short supply.

The medical staff has department chiefs in medicine, surgery, and obstetrics. There is an active tissue committee chaired by the pathologist but other staff committees are not too active.

Misericordia Hospital

This public hospital was built in 1929 as a large general hospital. It is owned and operated by the Sisters of Misericordia, a Roman Catholic religious order. In 1932, two of the floors were taken over by the Ontario Government as a provincial sanatorium which received grants on the same basis as the other sanatoria in the Province. This arrangement ended in 1959 and the sections were again turned for use back to the hospital. The building is in good condition and is well equipped with operating room, X-ray, laboratory, and other physical facilities. It has a rated bed capacity of 156 beds and 12 bassinets.⁶ The average over-all bed occupancy was about 80 per cent in 1962, exclusive of the chronic wing and women's section. There is a waiting list for the chronic wing and there is a long waiting list for the women's medical and surgical wing.

At the present time, there are 10 doctors on the active staff and four doctors on the courtesy staff, including the Medical Officer of Health. The laboratory director is a qualified internist with special training in pathology. The X-ray department is visited several times weekly by one of the qualified radiologists from Kirkland Lake. There are no active special staff committees at present. The

¹As of October 1962.

²Mainly registered nursing assistants.

³Approval of a course for two candidates a year was given in 1963.

⁴Approved course given at the hospital.

⁵Includes orderlies, kitchen, maintenance, housekeeping, and clerical staff.

⁶As of October 1962, there were 199 beds set up, divided into 88 chronic beds, 25 paediatric beds, 36 female medical and surgical beds, 39 male medical and surgical beds and 11 obstetrical beds. There were also 12 bassinets set up.

hospital administrator is the Sister Superior and the assistant administrator has had business experience. He is planning to take the Canadian Hospital Association extramural course in hospital administration.

The non-medical full-time staff number 253:¹

registered nurses (including some of the sisters of the order)	25
registered nursing assistants	63
nursing aids	21
orderlies	31
registered laboratory technologists	2
non-registered X-ray technicians	3
others ²	108

The hospital has been unable to obtain a dietitian and physiotherapist in spite of efforts to do so.

The hospital would like to be accredited, but the severe shortage of registered nurses and other qualified staff and the absence of the necessary medical staff organization make this difficult to achieve. The nursing shortage would be even more serious, were it not that several of the supervising sisters of the Order of Misericordia are registered nurses, and by the availability of some married nurses in the community. As a result, all of these are in supervisory posts and can do only emergency bedside care. The Order is a French-Canadian one and the hospital tends to be used by the French-Canadian community more than by the English-Canadian community. The latter group tends to go to the New Liskeard and District Hospital five miles away. Most of the French-Canadians are engaged in farming and mining and, thus, few of the married women have taken professional training or advanced education. The relative absence of business and industry means that few families with higher education and training are attracted to the area. The hospital could not carry on except for the use of registered nursing assistants for bedside care. There are even problems in getting and retaining a sufficient number of registered nursing assistants. The difficulty of providing qualified bedside nursing care of patients is a source of considerable complaint by doctors and patients and a matter of deep concern to the hospital.

The hospital has operated a course for certified nursing assistants since 1955.³ In 1961, the course was shortened from 18 months to 10 months by decision of the Province. The hospital regrets this change since their experience was that the graduates of the former course could be given certain skilled responsibilities whereas those from the present course cannot do so.

The chronic wing presents a number of special problems. Until recently it was the only such facility in the District and it remains the largest. It has proven difficult to get adequate medical supervision except by the salaried employment of an older doctor.⁴ In addition to the difficulty in obtaining nurses for the chronic care wing there is the additional problem that some staff members do not wish to

¹As of September 1962.

²Includes kitchen, maintenance, housekeeping and clerical staff.

³Now known as registered nursing assistants.

⁴Not recognized for reimbursement by the Ontario Hospital Services Commission. This doctor carried on a small general practice also.

care for elderly, chronic patients. The waiting list is long and the patient turnover is low.

New Liskeard and District Hospital

This recently built lay-owned public general hospital¹ has a rated bed capacity of 41 beds and 17 bassinets.² The physical facilities are good for a hospital of its size. The active medical staff consists of 10 doctors. Most specialized surgery is referred to Toronto or Kirkland Lake. There are no active special staff committees other than the general staff committee. The laboratory is supervised by the director of the laboratory in the Misericordia Hospital five miles away. One of the radiologists in Kirkland Lake visits the hospital twice a week. The dentists in the area use the hospital for extractions requiring general anaesthesia.

The non-medical full-time staff number 47: ³	
registered nurses	15
registered nursing assistants	5
registered X-ray technician	1
non-registered laboratory technician	1
others ⁴	25

There are 12 to 15 part-time registered nurses on the staff. Staff problems are few except for some nursing shortages in the summer months and the constant shortage of technicians. New Liskeard is a prosperous community with considerable business and small industry. Thus, many of the married women have special training, such as nursing. There is no physiotherapist and no dietitian but the hospital feels that, though they would be desirable, it could not use them adequately. Its size precludes accreditation consideration. The administrator has had business experience.

Chronic care is a problem. At present some beds are in use by chronically ill people but the hospital feels the need of a wing with six to eight beds for such people.

Englehart and District Hospital

This municipally owned public general hospital was a Red Cross outpost hospital opened in 1923. In 1955, the community took over ownership and operation. A new maternity wing was built in 1960. The physical facilities though limited, are good. There is a rated bed capacity of 34 beds and eight bassinets.⁵ The only active staff doctors are the three physicians in Englehart. There are no staff committees. One of the radiologists in Kirkland Lake comes to

¹Opened in 1952. The original hospital opened in 1906.
²The 1962 Canadian Hospital Directory reports 42 beds and 17 bassinets set up. 1962.
³As of October 1962.
⁴Includes orderly, kitchen, housekeeping, maintenance, and clerical staff.
⁵Consists of 28 medical and surgical beds, six obstetrical beds, and eight bassinets. The 1962 Canadian Hospital Directory reports the same number set up.

the hospital twice a week. The small laboratory is operated by the bacteriologist from the Kirkland Lake Hospital who comes twice a week. The administrator is a nurse.

The non-medical full-time staff number 46:¹

registered nurses	6
registered nursing assistants	4
nursing aids	7
orderly	1
others ²	28

The obtaining of such professional staff is a serious problem. This is a very small community and there are not too many potential people to draw upon. The doctors would like additional facilities, such as piped oxygen and auxiliary lighting service so that they could do more extensive surgery. The hospital feels that the problem of the chronically ill presents some problems, though not serious ones, since this hospital is reasonably large for the district it serves. There are a number of elderly and chronically ill people in the hospital who could be cared for elsewhere, if nursing home accommodation and a home for the aged were available.

General Comments

A number of problems present themselves in the hospital picture in the Timiskaming District. One of these is the serious staffing difficulty which all four hospitals are facing to a greater or lesser degree. It is less serious at Kirkland Lake, the largest community, and in New Liskeard, a relatively wealthy and middle-class town, but it is acute in Haileybury, and to a lesser degree in Englehart. This is the case for all categories of professional and technical staff. Except for laboratory technologists, X-ray technicians, and registered nursing assistants, there are no training facilities in the District. Thus, staff must be attracted to the region.

Another difficulty is the relatively limited medical staff organization, even in the accredited Kirkland Lake Hospital. Some doctors seem more or less unwilling to accept supervision of their hospital work by staff committees. The hospital boards and administrators seem reluctant to be overly vigorous in questions involving supervision and standards.

Another problem is that of chronically ill and aged people who do not really need general hospital care but who are in hospital because other services and facilities are limited. The Victorian Order of Nurses is active only in Kirkland Lake with one nurse.³ The Health Unit provides limited visiting bedside care services, but is hampered for economic and staff reasons from expanding the service.

Another difficulty the hospitals face is in providing rehabilitation facilities. The Ontario Society for Crippled Children⁴ and the Rehabilitation Foundation for the Disabled⁵ provide some service. There is a private physiotherapist in the

¹As of October 1962.
²Includes clerical, maintenance, housekeeping, and kitchen staff.
³See pp. 290-291.
⁴See p. 291.
⁵See p. 292.

Kirkland Lake area and also one at the Kirkland Lake Hospital. They are, however, hard to obtain and retain.

Ambulance care is also sometimes difficult to obtain as required, especially for low-income families.

Relations between the hospitals and the Health Unit are good.¹ The public health nurses visit all four hospitals (twice a week for the two larger ones and once a week in the two smaller ones), to call on all obstetric patients whose names have been referred by their physicians. The service includes the patients of all but one or two doctors and, therefore, covers most expectant mothers. In addition, the public health nurses provide limited visiting to cancer patients in the hospitals and on occasion to other patients referred by doctors, to help with arrangements after discharge from the hospital. In special instances, limited home nursing service is provided in the areas not served by the nurse of the Victorian Order of Nurses. The Health Unit is also related to the hospitals through the Medical Officer who is a consultant staff member in the Kirkland Lake Hospital.

OFFICIAL WELFARE SERVICES

Ontario Department of Public Welfare Regional Office

The Regional Office in Kirkland Lake serves the Districts of Timiskaming and Cochrane. There are four sub-offices, one of which is in Haileybury. The functions of the staff are to handle applications and to administer directly the statutory allowances provided jointly by the Dominion and Province and by the Province alone,² and general welfare assistance³ in unorganized areas, and to supervise generally the administration of general welfare assistance³ by the organized municipalities.⁴ Local welfare administrators, the Health Unit,⁵ and social agencies refer people to the offices as well as direct applications being made for the categorical allowances by the people themselves. The staff also look for eligible people when they are checking the local municipal general welfare assistance files.

As of October 1962, there were active files on:

- 500 Mothers' and Dependent Children's Allowance recipients
- 250 General Welfare Assistance recipients⁶
- 975 Old Age Assistance recipients
- 483 Disabled Persons' Allowance recipients
- 71 Blind Persons' Allowance recipients

2,279

¹See p. 279.

²These are Old Age Assistance, Disabled Persons' Allowance, Blind Persons' Allowance, and Mothers' and Dependent Children's Allowance.

³General Welfare Assistance Act, Revised Statutes of Ontario.

⁴Cost shared 50 per cent by the Dominion, 30 per cent by the Province, and 20 per cent by local municipalities. Certain permissive supplements up to \$20.00 per month may be paid at the discretion of local municipalities on an 85:25 per cent sharing basis between the levels of government and the municipality concerned.

⁵For example, for post-sanatorium allowance, etc.

⁶In organized and unorganized municipalities.

A number of serious welfare problems exist in this area. There are some isolated communities of Indians and Metis, whose living conditions are bad. Some live in tents throughout the year and depend upon fishing and trapping for a living. In turn, the health conditions are bad in these settlements.

Another problem in the area is that most lumbermen and many miners do not have any pension arrangements so that they have no financial support other than public assistance to depend upon in their old age. Quite a number are living in severely straitened circumstances and in substandard boarding accommodation.

Teck Township Welfare Department

In most of the municipalities in the District the local clerk-treasurer is also the local welfare administrator. Few of the municipalities provide benefits in excess of the minimum required by statute. There is also variation in the strictness with which the provisions of the General Welfare Assistance Act are interpreted.

Teck Township has a separate Welfare Administrator. Most of the people served are either those who are unemployable for health reasons but who are not sufficiently disabled to qualify for the categorical allowances,¹ or unemployed people, chiefly unskilled, who could work if jobs were available. On an individual case basis supplements are paid in the winter to those with large families, to the elderly for special medication, and rent, etc., and to those whose unemployment insurance benefits are inadequate. At best, however, the rates of payment are low. Premiums for hospital insurance under the Ontario Hospital Insurance Commission are paid by the Municipality of Teck Township only on behalf of those likely to be ill for one month or more per year. Otherwise the statutory *per diem* indigent rate is paid according to the number of days in hospital. Glasses are provided for elderly people on welfare, and the service clubs help with children. Only dental extractions are covered and any remedial work in children, or dentures in older people, are provided by the dentists at no cost or are paid for by service clubs. Certain medical needs are met through the Ontario Medical Welfare plan but some doctors have been reluctant to take patients thus covered.

Among the health-related problems seen by the local welfare authorities, for which satisfactory solutions are not at present available, are dental cases, borderline psychiatric cases needing some care but not certifiable, and elderly people, especially single men, who need care but are ineligible for the chronic care wings in the hospitals. Another difficulty is that of some families of low capacity, poor education, and multiple 'chronic' welfare needs.

The Welfare Administrator works closely with the Ontario Department regional staff, the Health Unit staff, and the Children's Aid Society staff, and other groups on specific cases.

ACCOMMODATION AND FACILITIES FOR THE AGED

The Northdale Manor, New Liskeard²

This is a home for older people sponsored by the United Church Board of Evangelism and Social Service. It is directly operated under the Board of three

¹This group includes miners who are often comparatively young but have moderate silicosis.

²There is also a boarding home in the District run privately for ambulant older people and taking up to a dozen people. It was not visited.

regional presbyteries and, in turn, by a local board for the home itself which meets monthly to set policy and dispense funds, etc. The Superintendent is a practical nurse. There are 15 single rooms and 10 double rooms, including married quarters for two couples. More men than women apply, since the older single male population tends to be higher proportionately in this area than elsewhere. The residents must be physically well and require only minimal supervision. If they become ill, only short-term care is provided. People with some senile changes may remain as residents, as long as there are no serious difficulties of co-operation, care, and adjustment.

The 1962 cost was \$77.00 per person per month. The provincial Department of Public Welfare will pay a *per diem* rate based on the means of the residents.

The home also receives assistance from the Board of Evangelism of the United Church, and from other United Church organizations, and, as they are able, the residents. Most are United Church people but other Protestant groups as well as several Roman Catholics are represented among the residents. Church services are arranged with the local ministerial association and the local priest cares for the Roman Catholic residents.

The home is extremely pleasant, comfortable, and well equipped. It meets the needs of people chiefly of a middle-class background.

General Comments

The problems of elderly people who are chronically ill and who require either institutional care or organized home care services have been described previously.¹ Older people who are ambulant and require minimal care present another problem. An organized home care programme would help. For those who could not live alone some type of satisfactory, low-cost boarding situation is needed. A particular problem in the area is that of elderly, single, and retired miners who are wholly dependent on the Old Age Security Pension. Good low-cost boarding situations with the exception of one small private boarding home and the home for old people operated by the United Church of Canada in New Liskeard are not available. In December 1962, in Kirkland Lake (Teck Township) a vote on the question of building a municipal Home for the Aged was passed by a large majority. The building of the Home may do much to relieve the need.

OTHER VOLUNTARY HEALTH AND SOCIAL SERVICES

The Victorian Order of Nurses, Teck Township

The Victorian Order of Nurses is active only in the Teck Township area with a staff of one nurse with public health training. Formerly there also was a nurse in the New Liskeard area, but the service was terminated several years ago for financial reasons and also because it was felt that the service was not being sufficiently used. The programme in Teck Township which previously had one full-time and one part-time nurse, consists of general home nursing care, such as bathing, injections, changing dressings, and prenatal and post-natal visits, as requested by doctors. The nurse will visit pre-natal patients once a month until term and then weekly until the baby is six weeks old. About one referral in six

¹See p. 287.

of those sent by the doctors to the Health Unit are passed on to the Victorian Order of Nurses. Also, some doctors refer some patients directly to the Victorian Order of Nurses. The maternal and infant programme accounts for about 76 per cent of the total case load. The nurse also will visit chronic patients, such as stroke cases, to provide some exercises and speech training, etc. This latter service is only being used to a small extent, partly because its availability apparently is not known to all doctors. Two hours a week in the form of a limited industrial nursing programme are provided to Weston's Bakery, one of the larger employers in Kirkland Lake. A home nursing course is provided once or twice a year as requested by the local area as well.

A local voluntary Board handles the budget and provides the nurse with a car. The 1962 revenue sources in round figures were:

Municipal grant	\$2,200.00
Fees charged ¹	1,367.80
Community Chest	1,600.00
Interest on bonds	45.00
	<hr/>
	\$5,212.80
	<hr/>

The main problems seen by the nurse arise from a lack of community facilities. There is no homemaker service, either voluntary or proprietary. This creates problems for expectant mothers with small children and for elderly people. For the latter group the absence of homes for the aged, nursing homes, and adequate boarding facilities for single people, especially men, also presents serious difficulties. About 88 per cent of the Victorian Order of Nurses home nursing care is for elderly people.

The Ontario Society for Crippled Children

The general organization and programme of the Society has been described previously.² The Society has a district nurse with public health training and a secretary at the office for the Districts of Timiskaming and Cochrane combined. Service is provided for children from birth to 19 years of age.³ The nurse works very closely with the Timiskaming and Porcupine Health Units. Two clinics a year are held by the Society in the District of Timiskaming at Kirkland Lake and at either New Liskeard or Haileybury. Specialists are brought from the Hospital for Sick Children in Toronto at the request of the local medical societies and children are referred by their family doctors to the clinics. The Society's district nurse follows patients and assists the family doctor in their care. She also makes arrangements for any children who, it is decided, would benefit from a period at the rehabilitation centre in Toronto. Transportation is arranged through whichever service club in a specific community is responsible for the local Easter Seal Campaign.

The Society also operates a crippled children's camp outside Kirkland Lake with an enrolment of about 160 children per season. The camp serves North Bay and Sudbury as well as Timiskaming and Cochrane.

¹Sliding scale \$0.0—\$2.25.
²See Appendix I, p. 205.
³In Timiskaming there were 288 children under supervision in 1962.

Revenues are obtained through the Easter Seal Campaign conducted by an associated service club in each community and from a grant by the McGarry Township Federated Charities.¹ One-half of the money collected is sent to the Society's headquarters in Toronto and one-half is kept locally for the operation of the camp and other local projects, other than salaries and administration. These last are paid for through the main office in Toronto.² Any additional money required for local programmes is sent from the head office.

The most acute need, as seen by the Society's nurse, is for physiotherapy. Another difficulty is the absence of speech therapy services locally. It is expensive to send children to Toronto for therapy. A third problem is that the schools, because of a lack of facilities and specially trained teachers, are reluctant to take children with orthopaedic handicaps.

Relations with the Health Unit are close, and joint visiting with public health nurses is common.³ There is also close liaison with the Rehabilitation Foundation for the Disabled.

Rehabilitation Foundation for the Disabled (March of Dimes)

The general organization and programme of the Foundation have been described previously.⁴ Services in Timiskaming are provided through a district office in Kirkland Lake which also serves the District of Cochrane. The staff consist of a case worker and a secretary. The District Branch Board and a medical advisor supervise the work. The medical advisor is a member of the provincial Medical Advisory Board and the Branch Board is represented on the provincial Board of Directors. Policy is laid down by these two bodies and its implementation is supervised by local representatives.

A medical assessment and follow-up clinic is held annually in Kirkland Lake to which patients are referred from the entire Cochrane and Timiskaming Districts. It is staffed by three orthopaedic specialists from Toronto who are on the Ontario Advisory Board. Diagnosis and recommendations for treatment are made to the family physician by written report. Arrangements for any treatment subsequently requested by a family doctor are made by the case worker. If the patient's own financial resources will not cover costs, the case worker arranges any necessary subsidization either through welfare, other local sources (service clubs, for example), or through Foundation funds. Foundation expenditures represent only that portion of needs not met by other sources.

Amputations and corrective work on stumps may be done by the surgeon in Kirkland Lake, but more complex orthopaedic procedures, such as reconstructive surgery and limb fitting, are performed at the Toronto General and Toronto East General hospitals. There is no rehabilitation centre in the area but the

¹The sum of \$6,222.40 was obtained in 1962 in Timiskaming. This includes \$450.00 from the McGarry Federated Charities.

²Approximate 1962 district office expenses were:

Salaries	\$ 8,990.00
Office	1,538.00
Travel and car maintenance	1,778.00
	<hr/>
	\$12,306.00

³See p. 279.

⁴See Appendix I, p. 206.

physiotherapy department of the Kirkland District Hospital is reasonably well equipped for minor needs. Patients requiring more intensive care are brought to a rehabilitation center in southern Ontario, usually the Frontenac District Rehabilitation Centre in Kingston. The local volunteer organization provides wheelchairs and other aids for people.

Work assessment is provided on a regular basis by a travelling psychologist. There is a sheltered workshop in Timmins. Various types of sub-contract work for the mines is carried out and some jewelry is manufactured from Canadian stones. The Society co-ordinates its work closely with that of the Ontario Department of Public Welfare Provincial Rehabilitation Service worker in the area, and a great deal of the costs of treatment and retraining are borne by that Department. Other provincial services such as the Provincial Trade School in Kirkland Lake and the Provincial School of Mines in Haileybury are also used.

In 1962, in Timiskaming there were 182 known cases of whom 129 were actively served in the year at a cost of \$10,001.20. Revenues come from local Community Chest grants, local March of Dimes campaigns, and, if necessary, from the Ontario main office. The sources of revenue received in Timiskaming and Cochrane in 1962 were:

March of Dimes Campaigns	\$11,834.16
Community Chest, Kirkland Lake	2,400.00
Federated Charities, McGarry Township	409.00
Miscellaneous	41.96
Refunds on equipment supplied, etc.	878.60
	<hr/>
	\$15,563.72

The total funds raised in Timiskaming, aside from refunds, were \$4,317.00 in 1962.

There is close liaison with the local programme of the Ontario Society for Crippled Children. There is also good liaison with the Health Unit, whose public health nurses are active in case finding and referral. The lack of physiotherapy in the area has hampered local care to some extent recently. There is now a physiotherapist at the Kirkland Lake Hospital but it is uncertain how long she will stay.

The Timiskaming District Tuberculosis Association

Monthly clinics are held in three areas as described under the Health Unit programme.¹ The clinic secretary of the Association attends all clinics, sends appointment cards and keeps all records. The Association pays for all chest X-rays, provides transportation to clinics when necessary and pays the salary of the clinic secretary.

The Association encourages the hospital admission X-ray programme. In Haileybury about 95 per cent of patients are X-rayed, in New Liskeard 58 per cent, in Englehart 90 per cent, and in Kirkland Lake 92 per cent, according to the last quarterly report for 1962.

The members visit homes and endeavour as well as they can, as lay people, to provide some comforts, clothing, and a measure of rehabilitation instruction. They also provide small personal needs, Christmas gifts, and local newspapers to people from the area who are in sanatoria.

¹See pp. 267-268.

The sole source of funds is from the Christmas Seal Campaign. To January 7, 1963, the funds raised amounted to \$8,872.22 for the current campaign. Assessment fees are sent each year to the Ontario and Canadian Tuberculosis Associations, and donations are sent to the International Union Against Tuberculosis Fund, to the Research Fund, and to the General Fund for the use of any local associations whose funds do not cover their programmes.

The Association feels that there is a greater need for rehabilitation than is being met. They depend heavily on the public health nurses to advise them of need but feel that a trained social worker would be of considerable value. Also there have been some problems in arranging retraining through the Departments of Public Welfare and of Education, which have programmes for vocational retraining. Many of the people who require retraining are of such a low educational level that they are not eligible under the existing programmes.

Another problem is that of getting information from the sanatoria on persons admitted and discharged. This information is available through the Health Unit but there is often some delay in obtaining it.

Canadian National Institute for the Blind

The general organization and programme of the Institute in Ontario have been described previously.¹ The Timiskaming District is serviced from a district office at Sudbury, which has a staff of field secretary, assistant field secretary, and a home teacher. In 1962, there were 67 registered blind people in Timiskaming, of whom 9 were 18 years of age or less. The number of prevention cases was 18. Money raised locally amounted to \$6,313.35 in 1962.² Expenditures for local work in Timiskaming were \$7,586.08.

The Canadian Red Cross Society

The general organization and programme of the Ontario Division have been described previously.³ There are organized Red Cross branches in Timiskaming for Kirkland Lake, Matachewan, Englehart, Haileybury, New Liskeard, and for Cobalt and Coleman Townships.

The Society sponsors the blood donor clinics which are held twice a year at Kirkland Lake, and twice a year in the tri-town area,⁴ twice a year in Englehart, and twice a year in Larder Lake. It also sponsors a water safety programme, looks after victims of fires and disasters, tries to assist immigrants from overseas coming into the area, and assists civilian inquiries for lost or missing persons.

In Kirkland Lake and McGarry Township, the branch is a member of the Community Chest and Federated Charities.⁵ Elsewhere, the branches obtain funds from donors from a file listing those who have contributed in the past and those who they believe are likely to be able to contribute.

¹See Appendix I, p. 209.

²Includes approximately \$3,040.00 from the Community Chest in Kirkland Lake and \$550.00 from the McGarry Township Federated Charities.

³See Appendix I, p. 212.

⁴New Liskeard, Cobalt, and Haileybury.

⁵Kirkland Lake Community Chest grant of \$2,800.00 and McGarry Township Federated Charities grant of \$650.00 in 1962. The Kirkland Lake Branch reported total revenue of approximately \$3,603.00 in 1962.

Canadian Cancer Society

The general programme of the Society in Ontario has been described previously.¹ In Timiskaming there are two units, one in New Liskeard and the other in Kirkland Lake. The latter has a branch in Englehart. The units are the responsibility of the volunteer boards. There is no paid worker in the District. Each unit includes the surrounding territory and about one-half of the District's population is in each unit area. The diagnostic and follow-up clinics have already been described.² The Society also provides transportation, cancer dressings, and certain drugs for patients. Some educational work is done in spreading knowledge of the early signs of cancer and the importance of seeking early care.

In the Teck Township area, the Unit is a member of the Community Chest. The branch in Englehart has a separate fund-raising campaign. For McGarry Township, money is received from the McGarry Federated Charities. The local Unit sends funds collected to the provincial office and draws on this office as required for local expenditures. The Unit also has a small fund of about \$150.00 from private donations for a "gift cupboard". The money is used for small gifts, flowers, special diets, and other special personal needs of patients not covered by the usual funds of the Cancer Society. The Timiskaming Unit's 1962 financial report showed receipts of \$5,668.42.

In the tri-town area,³ an annual appeal is made for funds. The money is divided into two accounts, the transfer account money which is sent to the provincial office, and a small working fund account which is kept for local welfare work. Other expenses of the Unit are covered from the provincial office as in the case of the Timiskaming Unit. The Ontario Division Office received \$3,987.10 from the Tri-town Unit in 1962.

One problem mentioned is the need for greater home nursing service in areas not served by the Victorian Order of Nurses. The Health Unit provides some service elsewhere but this is limited for staff and financial reasons. Closely related is the difficulty in obtaining housekeeping services, especially of a long-term kind. The distances⁴ and lack of home facilities in some instances make the provision of such services more difficult than in more settled parts of the Province.

Another problem is the distance to the nearest radiotherapy centre, the Princess Margaret Hospital in Toronto. A closer centre would be welcomed by the local Society members.⁵ The Society usually tries to upgrade the coach fare allowed from government funds for trips to Toronto. This can be a very costly item, particularly where repeated trips are involved.

The local Society units feel that there is also a need for further chronic care facilities, in addition to the section at the Haileybury hospital which is almost always filled. At present some general hospital beds are in use by chronic care cases.

¹See Appendix I, p. 211.

²See p. 278.

³New Liskeard, Haileybury, and Cobalt.

⁴For example, the Unit based at New Liskeard serves an area of about 2,000 square miles with a population of approximately 25,000, some of whom are in unorganized territory.

⁵Not in Sudbury, since it is easier to go to North Bay, and even Toronto is only overnight on the train. The Kirkland Lake and District Hospital radiologists would like to establish a limited radiotherapy programme.

Timiskaming Children's Aid Society

The staff consists of a director, a case worker supervisor, seven case workers, and five clerks. The programme covers foster home care for children up to 18 years, adoption placements, assistance to unmarried mothers, counselling on parent-child, marital, and other family problems, completing divorce investigations for the Ontario Official Guardian in cases involving children under 16 years of age, and conducting Family Allowance investigations on request. The 1962 budget was approximately \$155,000.00, of which approximately 93 per cent came from public grants¹ and 7 per cent came from private sources.² The former are for the statutory functions of the care of children under protection, and unmarried mothers. Other counselling activities must be covered from the other sources.

The needs pointed out include a mental health clinic for assessment and referral, medical and dental care for children in welfare families,³ a general family counselling service,⁴ juvenile detention facilities so children will not be lodged in the adult jails while awaiting court hearings,⁵ a home for teenage wards who cannot adjust to foster-home care and who need special counselling, and for children taken under protection, and community health and welfare councils to help co-ordinate planning and the provision of services. There is close liaison with the welfare authorities, the school authorities, the Health Unit, and most of the doctors.

The 1961 financial statement shows:

Income:

Municipalities and other Children's Aid Societies ..	\$107,799.38
Province of Ontario	20,643.38
Parents and others	5,073.42
Community Chest, private campaigns, grants	21,096.82
	<hr/>
	\$154,613.00

Expenditure:

Maintenance of children in care	\$ 84,979.12
Cost of services, salaries, travel	46,014.33
Administration (clerical salaries, rent, office supplies)	22,863.06

\$153,856.51

Surplus

756.49

\$154,613.00

Depreciation (automobiles, furniture)	\$ 2,640.50
Surplus in 1961	756.49

Net deficit

\$ 1,884.01

¹Municipalities—80 per cent, province—15 per cent, charges to parents and others—5 per cent. See Appendix I, pp. 215-216, and Appendix II, p. 256.

²Kirkland Lake Community Chest, Virginiatown Charities, (McGarry) Tri-town and Englehart Campaign, investigations.

³Those under care by the Society are covered.

⁴The Society has been forced to do some of this in the absence of other trained personnel but receives no grants beyond the statutory ones for child care and unmarried mother care.

⁵Now they may be thus detained for up to six days until the next hearing.

Other Agencies

Other agencies providing services with some health aspects which have not been described include the Retarded Children's Society and school and the John Howard Society, the Young Women's Christian Association and the assistance of church groups and service clubs with such individual needs as special drugs, special diets, and the costs of glasses and of dental care for children not covered under public programmes.

METROPOLITAN TORONTO FIELD STUDY

SOME GENERAL FACTS

The Municipality of Metropolitan Toronto is located in the County of York in southern Ontario. It is the capital of the Province of Ontario and the second largest urban metropolis in Canada. It is bordered by Lake Ontario on the south, by Peel County on the west, by Ontario County on the east, and by the remainder of York County on the north. The surrounding area is a rich mixed agricultural one, though more and more of the land is being taken over for housing and industrial use. The climate is warm in the summer but only moderately cold in winter.

Toronto's location makes it a natural meeting place between the Lake Ontario county to the south and the rich farm country to the north, and the woods and lake regions just beyond. First a portage site for the Indians and later a French trading site, it became an important small community in Upper Canada during the British regime under the name of York. A good natural harbour helped to make it a regional centre for the rapidly growing settlements to the west and north in the early 1800's, which gradually grew to out-distance its rival, Kingston, to the east. In 1834, the City of Toronto was incorporated. The area has grown rapidly as a political, educational, and business centre during the last part of the nineteenth century and especially during the present century.

Toronto is the capital of Canada's most populous Province, Ontario. In 1953, the city and 12 immediately surrounding municipalities¹ were given a metropolitan status with a federal system of local government. The individual municipal councils retain autonomy in many fields, but more and more the trend has been towards greater assumption of responsibilities by the Metropolitan Council² of 25 members. The latter body is made up of 12 elected representatives from the City Council and 12 from the other 12 component municipal councils, and by a chairman who may be elected by them either from their own number or from outside the Council. In general, the City representatives have favoured moves leading to a unification of area-wide services, whereas most of the other municipalities have opposed full amalgamation. The pattern of government is

¹An area of 240 square miles.

²Health and welfare services are provided by the individual municipalities, except for the hospitalization of indigents, homes for the aged, post-sanatorium care, and the maintenance of wards of the Children's Aid Societies, which are metropolitan responsibilities.

now under review and suggestions for re-dividing the region into several fairly equal population units, either boroughs or cities, have been made, as well as suggestions for amalgamation. The municipalities in Metropolitan Toronto are:

<i>Name</i>	<i>Incorporated as</i>	<i>Population</i>
1. Toronto	City	672,407
2. York	Township	129,645
3. North York	Township	269,959
4. East York	Township	72,409
5. Scarborough	Township	217,286
6. Etobicoke	Township	156,035
7. Leaside	Town	18,579
8. Weston	Town	9,715
9. Mimico	Town	18,212
10. New Toronto	Town	13,384
11. Swansea	Village	9,628
12. Forest Hill	Village	20,489
13. Long Branch	Village	11,039

The population as of the 1961 Census for Metropolitan Toronto was 1,824,481 people, an increase of 322,228 (51.0 per cent) since 1951.² The major group is of British Isles ancestry but about one-half are of other national background. A very large proportion of Canada's post-war immigrants have settled in the area and have given the City a richly cosmopolitan character. Formerly predominantly Protestant in religion, the numbers of Roman Catholics are increasing rapidly and will soon predominate in the City proper.

The growth of the City and the small municipal units have remained almost static, whereas the large suburban townships have shown dramatic growth. For example, the population of North York has been increasing by over 20,000 people per year during the last few years. Though the Metropolitan Toronto growth itself has been more than that of the Province as a whole during the decade, if areas just outside the boundaries are taken into account, the growth in the Toronto region has been even more staggering. Thus, one finds almost a solid urban development from Hamilton through to Oshawa and with small gaps through to St. Catharines, Welland, and Niagara Falls. In one sense, therefore, data on Metropolitan Toronto alone tend to mask the over-all rapid urban-industrial development in the part of the Province which is centred on Toronto.

Toronto today is a major financial and commercial centre with only Montreal as a somewhat larger rival. Approximately one-fifth of Canada's population lives in the economic area served directly by Toronto and these people represent about one-third of the country's purchasing power. Toronto has a large harbour which is an important trans-shipment site for all of Ontario and which has grown in importance since the opening of the St. Lawrence Seaway. It is a major freight and passenger terminus for both large railways. There is a large international airport on the northwest outskirts and a small airport on Toronto Island. There are excellent superhighways leading to and from the City in every direction. Extensive redevelopment of areas in the heart of the City has

¹Dominion Bureau of Statistics 1961 Census data.

²The percentage population increase for Ontario as a whole over the same period was 35.64 per cent.

been under way for several years and extensive plans for the entire future balanced growth of the area have been prepared. The cost of living is in general higher than in the rest of the Province but goods from all over the world are readily available.

Toronto is also a major cultural and educational centre with two universities, the older University of Toronto with about 17,000 students, located in the heart of the City, and the recently established York University with an enrolment soon to reach 5,000 students. Two suburban satellite universities to the University of Toronto, on the east and west, are soon to be developed. There are excellent public primary and secondary schools, separate primary schools, and a number of private schools. There are also good facilities for vocational and technical education and for children with various handicaps. A large polytechnical institute, the Ryerson Polytechnical Institute, serves the area and there are a variety of public and proprietary business and trade schools. Toronto also has a rich musical, artistic, and theatrical life. There is a large annual national exhibition. There are three large daily newspapers. A number of smaller local and weekly journals and several magazines are published in Toronto. There are several radio stations and two television stations from which a high proportion of nation-wide programmes originate. There are good parks and recreational facilities within the region and more are being developed. As well, the lakes and forest regions to the north lie within ready access to the City.

PUBLIC HEALTH

In Appendixes I to III detailed descriptions of public health services were given, but for Metropolitan Toronto a summary approach has been used, since it was felt that an over-all view would be more useful. For specific details, reference should be made to the annual reports of the individual boards of health.

General Organization

In Metropolitan Toronto there are 12 appointed Boards of Health. Eleven are municipal Boards. One is the Board of the East York-Leaside Health Unit. The board of health of a municipality is appointed by the municipal council at its first meeting each year and includes one member appointed by the Lieutenant-Governor in Council.¹ The members appointed by council are appointed for one year, whereas the member appointed by the Lieutenant-Governor in Council is appointed during pleasure. The composition of a local board is stipulated in the Ontario Public Health Act² according to the population of the municipality concerned. The membership of the boards in Metropolitan Toronto varies from three to eight people.³

¹In practice, this means the Ontario Government.

²Public Health Act and Regulations, Revised Statutes of Ontario, 1961.

³It is interesting to note that although the Act specifies the mayor or reeve to be a member of a municipal board of health, in practice this is not always followed.

COMPOSITION OF BOARDS OF HEALTH, 1961

Municipality	Total Members	Medical Officers of Health a Member	Mayor or Reeve a Member	Council Members	Medical Profession Member	Education Board Member	Other Ratepayer Members
Toronto.....	7	Yes	Yes	3	1	1	—
			Ex-officio				
Scarborough.....	7	Yes	Yes	1	1	—	3
York.....	7	Yes	Yes	1	—	—	5
North York.....	5	Yes	Yes	3	—	—	—
Etobicoke.....	5	Yes	Yes	2	—	—	1
Forest Hill.....	3	Yes	Yes	—	—	—	1
Weston.....	5	Yes	No	2	—	—	2
Swansea.....	3	Yes	Yes	—	—	—	1
Mimico.....	5	Yes	No	2	—	—	3
New Toronto.....	6	Yes	No	—	—	—	4
Long Branch.....	8	Yes	No	1	—	—	6
East York-Leaside.....	7	No	No	3	1	1	*2

*One appointed by the Ontario Provincial Government.

It is the duty of a local board of health to superintend and ensure the carrying out of the Public Health Act and its regulations and of any by-law of a municipality related to public health. A health unit board, for example East York-Leaside, is also responsible for general policies and programmes, for fiscal policies, and for personnel policies, including the engaging and dismissing of staff members. Other responsibilities include the collection of revenue from local, provincial, and federal sources and the making of all disbursements through an appointed secretary-treasurer.

Staffing

The medical officers of health as well as other staff members (with some exceptions where additional part-time staff are employed for special duties) serve full time in Toronto, York, North York, Scarborough, Etobicoke and East York-Leaside. The medical officers of health and some staff members serve part time only in Weston, Mimico, New Toronto, Long Branch, Forest Hill and Swansea. However, there usually are one or more members of the public health nursing staff who work full time on the local public health programme in these municipalities.

The numbers of persons on the staff vary from about four to six in the smaller municipalities to as many as 500 or more in the City. Obviously, the larger and more complex the administration the greater the number of specialists employed. Thus the City has the largest, most complex, and most comprehensive public health service available in the Metropolitan area, whereas the smaller municipalities tend to have only basic, minimum services available.

There is free exchange of ideas among the area medical officers of health through periodic meetings. These are helpful in deciding policy on programmes of a Metropolitan-wide nature, for example, the mass poliomyelitis vaccine programmes.

A) STAFF¹ BY CATEGORIES

Municipality	Medical Officers of Health		Other Physicians		Public Health Nurses		Other Registered Nurses		Sanitary Inspectors		Dentists		Dental Hygienists		Registered Nursing Assistants		Veterinarians		Clinical		Other		Total	
	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P
York	1	—	—	4	25*	1*	1	—	4	—	—	11	—	—	2	—	—	—	8	—	4 ²	—	45	16
North York ..	2	—	—	7	34	13	—	1	11	—	7	22	—	—	—	—	—	—	9	—	9 ³	22 ⁴	72	65
Etobicoke ..	1*	—	—	6	27	2	2	1	7	—	—	—	—	—	—	—	—	—	5	—	—	—	42	9
Scarborough ..	2*	—	1708 hrs	—	42***	3	4	777 hrs. V.O.N.&St. Elizabeth Nurses	8	—	1	—	1**	—	—	—	—	—	13	—	—	—	71	3
East York- Leaside ..	1	1	—	6	21	—	1	—	4	—	—	1	—	—	—	—	—	—	5	1	1 ⁵	—	33	9
Mimico	—	1	—	—	—	2	—	—	1	—	—	—	—	—	—	—	—	—	—	1	—	—	—	5
New Toronto	—	1	—	—	2	1	—	—	1	—	—	—	—	—	—	—	—	—	—	1	—	—	3	3
Weston	—	1	—	—	3	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	3	2
Forest Hill ..	—	1	—	2	4	—	—	1	1	—	—	2	—	—	—	—	—	—	1	—	—	—	6	6
Long Branch	—	1	—	—	1	1	—	—	—	1	—	—	—	—	—	—	—	—	—	1	—	—	1	4
Swansea	—	1	—	—	1	—	—	—	—	1	—	1	—	—	—	—	—	—	—	1	—	—	1	5

***3 vacancies.

** 2 vacancies.

*1 vacancy.

P — part-time.

F — full-time.

¹As per 1962 Annual Reports.²One psychiatrist, 1 psychologist, 2 social workers (1 vacancy for a social worker).³One Board of Health engineer, 1 septic tank inspector, 7 dental assistants.⁴Twenty-two dental assistants.⁵One dental nurse. A provincially provided mental health clinic of 1 psychiatrist, 1 psychologist, 1 social worker, and 1 secretary serves the area, from quarters provided by the Health Unit. They are not included in the above.

B) CITY OF TORONTO STAFF BY CATEGORIES¹

Medical Officers of Health	Other Physi- cians		Dentists		Dental Hygie- nists		Dental Assist- ants		Dental Techni- cians		Veteri- narians		Sanitary Inspectors		Public Health Nurses		Registered Nurses		Registered Nursing Assistants		Psycho- logists		Nutri- tionists		
	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	
16 ²	—	2 ³	80 ⁴	10 ⁵	29	3 ⁶	—	1 ⁷	28 ⁸	11	—	6	—	57 ⁹	—	196 ¹⁰	—	10	2 ¹¹	22 ¹²	—	7	—	2	—

Statisti- cians	Ambu- lance Personnel		Labora- tory Techni- cians		Beauty Parlour Inspector		Food Handlers Investi- gators		Rodent Control Officers		Audioma- tric Techni- cian		Drivers		Clerical & Secretarial		Telephone Operators		Total	
	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P	F	P
1	—	47	—	2	—	1	—	2	—	7	—	1	—	3	—	106 ¹³	1	—	514	139
																several (varies)				+clerical

F — full-time.

P — part-time.

1. As supplied by the Medical Officer of Health for July 1, 1963.

2. One vacancy.

3. Psychiatrists for mental health service to separate schools. Board of Education has its own service for the public primary and secondary schools.

4. Includes 8 general physicians; 4 consultants in hearing, ophthalmology, orthopaedics, and cardiology; 1 doctor on night and weekend call;

4 immunization clinic doctors; 1 director of home care project; 2 jail physicians; 1 doctor for pre-employment examinations; 22 child health centre physicians (3 vacancies); and 37 chest clinic physicians.

5. Includes 1 orthodontist.

6. Five vacancies.

7. Five vacancies.

8. Two vacancies.

9. Three vacancies. There are, however, 2 trainees being sponsored.

10. Fifteen vacancies.

11. Staff of the night clinic.

12. Two vacancies.

13. Seven vacancies. If filled, the part-time clerical staff would be reduced accordingly.

The basic staff available in all public health jurisdictions are the medical officer of health, public health nurses, and the sanitary inspectors. The numbers of each depend on the size of the municipality served. In the larger departments of health there may be general physicians, registered nurses, registered nursing assistants, and certain specialists employed. The specialist group includes psychiatrists, paediatricians, veterinarians, social workers, psychologists, nutritionists, health educators, statisticians, and other personnel. Thus the staff composition of a local health department may be relatively simple and small in size or be complex with a wide variety and large number of members. Salary scales vary but in general are among the top ranges in the Province.

In turn, the nature and extent of services provided vary from one municipality to another depending upon the types and numbers of staff members employed. The chart shows the staff members for each municipality as of December 31, 1962.

Financing

The annual budgets for the various health services in the Metropolitan Toronto area vary from under \$9,000.00 for Mimico to as much as \$2,754,314.00 in the case of the City of Toronto. The annual per capita expenditure varies from about 50 cents to over \$4.00. In the first instance the staff is all on a part-time basis, whereas the municipality with the highest per capita expenditure has a large and varied full-time staff.

The major source of revenue for all of the health departments is municipal tax funds. In addition there are grants-in-aid from the Ontario Government for certain special programmes. There are also special funds available from National Health Grants which are paid through the Ontario Department of Health to municipal health departments for special purposes. In Ontario the federal grants are only available to a local health department having an acceptable base-line of staff and service, as approved by the Ontario Department of Health. The grants assist in carrying out special studies and projects, such as the Pilot Home Care Programme of the City of Toronto Health Department. They may also be used as in East York-Leaside for starting new programmes, such as the employment of a public health educator, and for an extension of service, such as the employment of additional public health nurses for enlarging the secondary school health programme.

In the case of health units, of which East York-Leaside is an example, the Ontario Department of Health also makes a percentage grant toward the annual operating costs of the health unit. The grant varies according to the size and available tax resources of the area concerned.

The following table outlines the revenue and expenditures of the Boards of Health in Metropolitan Toronto for 1961:

PUBLIC HEALTH FINANCING, METROPOLITAN TORONTO, 1961

Municipality	Revenue			Expenditures		
	Local Sources	Province	Federal	Total	Salaries	Rent, Materials, etc.
Toronto.....	\$ 2,754,314.00	\$ —	\$ 81,085.00	\$ 2,835,399.00	\$ 2,458,146.00	\$ 296,168.00
Scarborough	389,170.00	18,000.00	30,000.00	437,170.00	Special Projects	81,085.00
York	224,610.66	—	24,467.00	249,077.66	346,800.00	90,370.00
North York	356,893.00	2,000.00	—	358,893.00	204,798.18	44,279.48
Etobicoke	255,090.14	—	—	255,090.14	271,999.00	86,894.00
Forest Hill	36,929.00	—	* 5,217.05	260,307.19	195,085.38	65,221.81
Weston.....	20,000.00	—	—	36,929.00	34,874.00	2,055.00
Swansea	11,483.90	—	—	20,000.00	15,700.00	4,300.00
Mimico.....	8,838.38	—	—	11,483.90	9,547.54	1,936.36
New Toronto, ...	18,741.04	—	—	8,838.38	8,190.00	648.38
Long Branch, ...	9,591.49**	—	—	18,741.04	15,138.00	3,603.04
East York- Leaside.....	137,198.27	42,109.43	24,600.52	9,591.49	8,947.30	644.19
				203,908.22	155,474.52	48,433.70
						203,908.22

*First quarter only. No grant being received at the end of the fiscal year.

**Includes an amount of \$6,198.57 recovered from the local Separate School Board and the local Public School Board for nursing services supplied to them.
Source: Prepared from data supplied by the public health departments concerned.

Internal Administrative Pattern and Facilities

The internal administrative pattern and facilities for a local health department may be very simple in a small municipality. Thus, office space and staff may be shared with other municipal departments. For example, a sanitary inspector may also serve as the municipal building or plumbing inspector. A public health nurse may have her office in a school building.

On the other hand, a large municipality, such as the City of Toronto, has a much more complex internal administrative pattern and much more extensive facilities. In the City, the central administration is divided into nine divisions and sections each headed by a qualified specialist staff person and each responsible for a special programme or service. The City is divided into eight geographical districts each with a district office and its own staff. The district staff comprise a district medical officer, public health nurses, sanitary inspectors, and clerical staff. The district office is responsible to the central office and, in turn, to the Medical Officer of Health. He is responsible for the entire Department to the City Board of Health.

Between these extremes fall the larger municipal health departments of the Metropolitan area. These departments have relatively large staffs, including some specially trained personnel, but there is less divisional organization than in the City Department. A common administrative arrangement is to have a director of nursing, a senior sanitary inspector, and a senior clerical person. Each is in charge of the respective staff members and responsible to the Medical Officer of Health. Sometimes, there may also be a full-time assistant medical officer of health, a director of dental services, and a director of mental health services.

Programmes

Sanitation

This is one of the statutory services provided by a local health department and many sections in the Ontario Public Health Act refer to this responsibility. The field encompasses a large number of inspectional and supervisory functions on the part of veterinarians, sanitary inspectors, plumbing inspectors, and the medical officers of health, as well as other specialized workers such as public health engineers, etc. The activities may, for convenience, be divided under certain general headings:

FOOD CONTROL

This includes the routine inspection of various premises, special investigations, education enforcement, and condemnation. Premises covered include general restaurants and snack bars, retail food stores and vendors, dairy farms, milk and cheese processing plants, local slaughter-houses and meat processing plants, food vending machines and premises, soft drink manufacturing plants, and frosted food locker plants. Part of the programme involves education of food handlers and management personnel. This may be done through "schools for food handlers" using various audio-visual instructional methods. Pamphlets are also used from time to time to re-enforce such instruction. Usually most teaching is by direct staff contact during inspection visits. In the event of premises becoming unsatisfactory and the usual methods of advice and suggestion proving unsuccessful, condemnation and prosecution may be used as a final resort.

GENERAL SANITATION

General inspection of barber shops, hairdressing establishments, second-hand stores, swimming and wading pools, bathing beaches, carnivals and exhibitions are routine procedures in most health departments, as well as the investigation of alleged nuisances. Investigation of citizens' complaints also requires a considerable amount of the time of sanitary inspectors. These may include complaints about the presence of rodents, insects, and odours in or about dwellings or other buildings in the community.

Sewerage system investigations usually result from complaints of flooded basements following heavy rain storms, or as a result of blocked drains. These may be referred to the works or plumbing departments as well. Close co-operation exists between health departments and works departments.

Routine testing of water supplies, both public and private, requires the collection of samples by the inspectors for submission to the public health laboratory. An inspection of all school buildings is required once each year.

Qualified sanitary inspectors of the local health department carry out these routine inspections and special investigations under the direction of the medical officers of health. Their work is varied and requires a diversity of knowledge.

In the Metropolitan Toronto area provision is made in all the municipalities for sanitation inspectional and investigational services. The extent of the service and the frequency of the inspections vary considerably. Because some of the municipalities have only a part-time inspector and the ratio of inspectors to population is low, the frequency of inspections is less than in the municipalities with large, full-time sanitarian staff and higher inspector-to-population ratios. It is extremely difficult to indicate these data statistically without knowing in detail the number of places requiring inspection, the co-operation of proprietors, and other factors not readily discernible, without detailed observation over a period of time. For example, it may be desirable to inspect some premises weekly, whereas other similar ones may require only monthly inspection. In general, however, the larger municipalities are more likely to provide more frequent, routine inspection services. Common examples of routine inspections would be for restaurants, butcher shops, and bakeries once a month and for slaughter-houses once every three months.

Communicable Disease Control

GENERAL AND IMMUNIZATION

This service was also one of the earliest to be recognized as a community responsibility. The Public Health Act of Ontario, and to some extent the Quarantine Act of the Dominion of Canada, impose certain statutory responsibilities on a local board of health and its medical officer of health concerning communicable diseases. The local municipality is required, through the clerk, to report all cases of communicable diseases and resultant deaths to the Ontario Department of Health each week. The regulations under the Public Health Act list all reportable diseases. The practising physicians are required by the Act to report to the local medical officer of health all cases of communicable disease which they attend. The responsibility for reporting also extends to the head of a household and to the principal of a school. The regulations under the Public Health Act list the applicable isolation and quarantine measures to be adopted. It is the responsibility of the local medical officer of health to carry out these measures.

Other measures designed to assist in the control of communicable diseases include the supervision and treatment of public water supplies, the proper treatment and disposal of sewage, the sanitary disposal of garbage and refuse, the control of rodents which may convey disease, and the spraying of breeding places for insect vectors.

Immunization against diseases for which specific protective measures exist has been of great value in reducing the incidence of diseases, such as smallpox, diphtheria, tetanus, and poliomyelitis.

Each of the health departments in Metropolitan Toronto provides a service in communicable disease control. The isolation and quarantine regulations relate to the whole Province of Ontario and are, therefore, uniform in application for practical purposes. The sanitary inspectors interpret the regulations as to isolation and quarantine, explain the measures to be taken to protect home contacts, and outline methods of concurrent and terminal disinfection to the people affected.

Immunization clinics for primary immunization are available for infants and pre-school children in all Metropolitan Toronto municipalities.¹ The clinics are commonly held in several centres in a municipality at monthly intervals. Reinforcing immunization is offered to the school-age population at regular intervals.²

Most municipalities also provide an opportunity for adults to receive immunization, usually against smallpox, tetanus, and poliomyelitis. These clinic centres may be held as often as five days a week or as little as every two to four weeks, depending on the size of the municipality and the public request for the service.

The City of Toronto Health Department operates an ambulance service, which includes use for communicable disease cases, and is the only Metropolitan Toronto municipality offering this service. When essential, the City provides this facility, usually for a fee, to adjacent communities in the Metropolitan area.

For many years the City of Toronto also operated an isolation hospital for the treatment of infectious diseases. Recently, however, the hospital was taken over by the Metropolitan Toronto Council's Welfare Department. It is now used to care for chronically ill patients. Some isolation facilities are to be made available in an emergency, but the difficulty experienced by the hospital's administrative staff in making arrangements in an emergency was seen in recent years when it became necessary to isolate a case of smallpox and later to find suitable accommodation for carriers of diphtheria. Arrangements are being made for the provision of minimum permanent facilities for the isolation of patients who cannot be cared for adequately at home.

TUBERCULOSIS CONTROL

The very active community programmes for the detection and treatment of tuberculosis have shown most encouraging results, both in the dramatic reduction

¹Diphtheria toxoid, pertussis vaccine, tetanus toxoid, Salk polio vaccine, smallpox vaccine.

²Diphtheria toxoid, tetanus toxoid, Salk polio vaccine, smallpox vaccine.

in mortality rates and in the much shorter average period of treatment in sanatorium. The public health nurses visit pre- and post-sanatorium patients as indicated. Chest clinics are held in the various general hospitals. The Gage Institute provides chest X-ray services free to the general population.¹ Hospital admission chest X-ray programmes are in effect. An active school tuberculin-testing programme, with a follow-up chest X-ray where indicated, is carried on in the various municipalities.

VENEREAL DISEASE CONTROL

In the field of venereal disease control the local health departments are responsible for assuring that treatment is available, free of charge if need be, either in established clinics or by payment to private physicians. The necessary drugs are provided to physicians free by the provincial health department. The physician reports cases of venereal disease direct to the Ontario Department of Health. The responsibility of the local health department is to ensure that treatment is completed, if a patient defaults, and to follow reported contacts to ensure adequate examination and treatment, if required. In Metropolitan Toronto special examination and treatment clinics are established in general hospitals throughout the area.

Maternal and Child Health

In the field of maternal and child health, the public health departments provide mainly an educational and advisory programme. Prenatal medical care is provided by the attending physician or the out-patient clinic of the general hospitals in the area. None of the health departments operates prenatal clinics distinct from the hospitals.

The prenatal education programme in Metropolitan Toronto is a twofold one. First, the Metropolitan Toronto Social Planning Council, Prenatal Committee, provides special classes for parents. These classes, usually eight or so to a series, are held in widely distributed centres throughout the Metropolitan area. There are several series each year in all areas. Instruction is provided by physicians and by public health nurses from the health departments, the Victorian Order of Nurses, and the St. Elizabeth Nursing Association. Classes are open to both fathers and mothers. A small fee is charged to cover operating costs. The curriculum includes lectures and demonstrations on basic topics related to pregnancy and baby care. A course of relaxing exercises is offered also to expectant mothers whose attending physicians have given their approval. This is an example of a Metropolitan-wide programme initiated by a voluntary agency but provided jointly by the staffs of the local health departments and members of the voluntary nursing organizations.

Secondly, home visits to prenatal patients are provided both by the public health nurses from the health departments, and by the Victorian Order of Nurses and St. Elizabeth Nursing Association nurses. These visits are made at the request of attending physicians or hospital clinics. In some of the smaller municipalities, the service is a limited one, whereas in the larger municipalities it is more complete and involves a good deal of public health nursing time.

¹ Operated by the National Sanitarium Association, a voluntary organization affiliated with the Ontario and Canadian Tuberculosis Associations and largely financed through the Christmas Seal campaign.

Almost all confinements in Metropolitan Toronto take place in hospital, and home confinements are non-existent for practical purposes.

Routine post-natal visits to the homes on receipt of birth registration notices by either municipal public health nurses or those of the Victorian Order of Nurses and St. Elizabeth Nursing Association are made in all municipalities except one relatively wealthy community where the service is only provided at the request of a physician or hospital clinic. Public health nurses are attached full time to the general hospitals by several municipalities, for example, the City of Toronto and East York—Leaside. These public health nurses provide a hospital health service and among other duties may visit new mothers in hospital with the consent of the attending physicians. If there is an indication for home visiting following discharge from hospital, a referral to the public health nursing service of the health department concerned can be readily arranged. Most of the health departments said that delay in receiving notification often results in visits being possible only some days or even weeks after a mother's return home. It is their experience that mothers, especially those with a first child, welcome assistance and advice, particularly if available immediately on returning home.

In the field of infant and pre-school child development and care, conferences are provided routinely in all areas but one, Forest Hill Village. This smaller municipality is largely a wealthy residential community and most families have their infants and pre-school children under a physician's supervision. In all other communities child health conferences or well-baby conferences are established to provide an opportunity for discussing with a public health nurse any questions related to the normal growth and development of the infant and young child. In some of the larger full-time public health departments, Toronto, Etobicoke, Scarborough, East York—Leaside, there are child health clinics with physicians in attendance who offer advice and carry out routine examination of infants. It is stressed that these are not treatment centres but are for the healthy child. Referral for any treatment required is made to family doctors and hospital clinics. The conferences and clinics are located conveniently throughout the larger municipalities, usually in neighbourhood schools, churches, or other public buildings. In the smaller municipalities one or two central locations are used. The clinics or conferences are held at weekly intervals in most areas but may be bi-weekly or monthly in a few others.

Child Health Centres

Municipality	Physician Present (Clinic)	Public Health Nurse Present Only (Conference)
Toronto	X	
Etobicoke	X	
North York		X
York		X
Scarborough	X	
Weston		X
Swansea		X
Mimico		X
New Toronto		X
Long Branch		X
E.Y. -Leaside	X	
Forest Hill	None provided	

In most child health centres, primary immunization is available. Protection against diphtheria, whooping cough, tetanus, and poliomyelitis is provided in a combined antigen. Vaccination against smallpox is also recommended during the first year of life and is available. In one or two areas, the immunization clinics are held separately from the regular clinics or conferences once a month. This service is offered to all infants in the community without regard to the financial status of their parents.

It is the usual experience that attendance at child health centres tends to be discontinued by the time the child reaches 18 to 24 months. A public health department often has little contact with the child from this time until he or she starts school, except through a home visit by a public health nurse on request or for some other reason.

Infant boarding homes are supervised and registered by the local medical officer of health. Many of the infants are placed in the homes by child-placement agencies, such as the Children's Aid Societies, the Infants' Home, and others, but private placement may also occur. The majority of these homes are located in the larger municipalities.

School Health Service

Some form of school health service is available in all 13 municipalities of Metropolitan Toronto. There is, however, considerable variation in the nature and application of the programme. The purpose is to ensure a satisfactory environment for the school child, to minimize the spread of communicable diseases, and to try to ensure that every child is in the best possible physical, mental, and emotional health so he may benefit fully from his education experience.

To this end the Ontario Public Health Act requires a complete report of a sanitary inspection of all publicly supported school buildings in its jurisdiction to be submitted by a local Medical Officer of Health to the Ontario Department of Health each year. In addition the school health service by means of physical examinations by physicians, physical inspections by public health nurses, and special vision, hearing and other testing, endeavours to detect any defect and notify the parent of the need for corrective measures.

In recent years it has increasingly become the practice to request parents to provide a report, on a form supplied, of a complete physical examination of the child by the family physician at the time the child commences school. This is the approach in most of the Metropolitan Toronto municipalities. In those instances where the parents do not return a completed examination form, an opportunity is given to the parents to request that an examination be provided by the school physician. In some of the smaller communities a public health nurse may do a superficial inspection and no medical examination is provided. However, in the case of North York the local health department provides a basic physical examination by school physicians for all Grade I students with the consent of the parents.

Some health departments request a further routine physical examination by the family physician at a later stage in the child's school career, often in Grade IX. Again, those not examined by the family doctors may be offered an examination by the school physicians. On the other hand, some health departments offer

routine physical examinations to all children in certain grades. For example, one municipality provides routine examinations in Grades I, VII and XI; another offers routine examinations for all Grade IX students. Other areas do not provide routine examinations but offer special examinations for those children known to have defects. These examinations are available at any interval recommended by the school physician. Any examination requiring removal of clothing must have parental consent, either by being present at the examination, which is encouraged, or by signature on a permission form.

SCHOOL ENTRANCE MEDICAL EXAMINATIONS

Municipality	Examination by Family Physician	Examination by School Medical Officer of Children not Examined by Family Physician	All Examinations by School Medical Officer	Nurse Inspection only of Children not Examined by Family Physician
Toronto.....	X	X		
Etobicoke.....	X	X		
York.....	X	X		
North York.....			X	
Scarborough....	X	X		
East York-Leaside	X	X		
Long Branch ...	X			X
New Toronto ...	X			X
Mimico.....		Service provided by Board of Education		
Weston.....	X	X		
Forest Hill.....			X	
Swansea.....			X	

Some health departments provide physical examinations for all students engaging in competitive sports, whereas others require parental consent in writing together with the family physician's report of examination. Thus, there is no uniform policy in respect to this service. In other areas, particularly the smaller municipalities, there may, in fact, be no regular school medical service and the public health nurses provide the service by inspection at regular intervals.

Provision is made in all the school services for routine testing of vision and hearing. The visual testing usually involves the use of a standard Snellen chart and is carried out by a public health nurse. However, in one municipality the College of Optometry provides a vision screening service for the schools at the request of the local Board of Education. Tests are repeated routinely at specified grades.

Gross testing for hearing acuity is done in some municipalities by the public health nurses using the spoken and whispered voice method. Larger municipalities provide an audiometric test which is a much more precise screening procedure. The tests using an audiometer may be carried out by specially trained technicians or by public health nurses.

Children found to have either visual or hearing defects are referred to their family physician or to specialist clinics for more precise evaluation and corrective treatment. In the event that the defect is so severe that the child cannot carry on in the regular classroom, special sight saving classes and hard of hearing classes are available in the City of Toronto. By arrangement, pupils are accepted from other Metropolitan Toronto municipalities.

SCHOOL VISION AND HEARING TESTING

Municipality	Vision		Hearing	
	By Nurse	By School of Optometry	By Nurse	Audiometer
Toronto.....	X			X
Etobicoke.....	X			X
York	X		X	
North York.....	X			X
Scarborough.....	X			X
East York-Leaside	X			X
Long Branch ...	X		X	
New Toronto ...	X		X	
Mimico	X	X	X	
Weston	X	High School	X	
Forest Hill.....	X		X	
Swansea.....		X	X	

At the secondary school level there has been an increasing health programme provided in most municipalities. The emphasis is placed on encouraging the student to take greater interest and responsibility for his own health. The school physicians, where provided, and the public health nurses find that a great deal of their time is occupied in personal health counselling. In this connection, three of the larger municipalities have special mental health services. The City of Toronto Board of Education has its own staff of psychiatrists, psychologists, and social workers. The City Health Department provides a comparable mental health service for the separate schools. In three municipalities, York Township, East York Township, and Leaside, local mental health clinics are available for the referral of school children. The other municipalities refer patients to out-patient mental health clinics in several of the general hospitals and to the three mental hospitals in Metropolitan Toronto.¹ There are also two mental health clinics operated by voluntary agencies in Toronto. All larger municipalities have psychologists attached to Board of Education or Health Department staff for conducting routine psychometric tests to assist in assessing academic ability and progress. Thus, the Metropolitan Toronto area is well supplied with mental health facilities in comparison with many other areas of the Province. Even so, there is increasing demand for an extension of the services.

A public health nurse in all municipalities in Metropolitan Toronto spends a considerable proportion of her time in duties related to the school health service. It is common practice for a nurse to spend most, if not all of her working morning in the school or schools which she serves. Her time is spent on

¹The Ontario Hospital in Toronto, the Ontario Hospital in New Toronto, and the Toronto Psychiatric Hospital.

interviews, routine inspections, admissions and exclusions in cases of communicable disease, preparing for the visits of the school physician, conferences with teachers, and routine testing procedures. The nurse also does home visiting in connection with the school health programme.

A school dental service employing dentists on a full-time basis is provided by the local health department in five of the six municipalities which have full-time public health services. Two of the six municipalities with part-time services employ dentists on a part-time basis for their school dental services. The most common school dental programme provides routine dental examination and dental education. Treatment is usually limited to dental emergencies occurring while the child is in school and to the care of children who are wards of the Children's Aid Societies, or whose parents are in receipt of public assistance. There are three exceptions to this general pattern in the Metropolitan Toronto area. In three large municipalities dental treatment, except that of a special nature such as orthodontia, is available to all school children at the request and with the permission of their parents. In one of these municipalities, North York, the budget for this service approaches one-third of the public health department's total annual expenditures.

SCHOOL DENTAL SERVICES

Municipality	No Health Department Service	Examination and Education	Treatment of Indigents Only	Treatment for All on Request
Toronto.....	X	X		X
Etobicoke.....				
North York.....		X		X
York.....		X		X
Scarborough.....	X	X		
Weston.....				
Swansea.....		X		
Mimico.....	By Board of Education			
New Toronto.....	X			
Long Branch.....	X			
Forest Hill.....		X	X	
East York-Leaside.....		X	X	

In the Metropolitan municipalities the local health departments provide an opportunity for the school child to receive reinforcing immunization during school life against smallpox, diphtheria, tetanus and poliomyelitis, at least to Grade VIII, and in a few instances through secondary school.

Mental Health

Mental health services are provided by the municipalities in Toronto and York Township. The Division of Mental Health of the Ontario Department of Health provides a full-time mental health clinic to serve East York—Leaside. Mental health services are provided by out-patient departments in the larger

general hospitals and three mental hospitals in the Metropolitan Toronto area. Two clinics are provided by voluntary agencies, the Canadian Mental Health Association and the Social Planning Council of Metropolitan Toronto. Recently, public health departments have been assuming a more active role in the home supervision of persons with mental illness. This may be in the nature of home visits by public health nurses and/or social workers following discharge from hospital or while under the care of an out-patient clinic. The local health departments also are frequently requested to assist in arranging mental hospital admissions and in providing transportation to clinics and hospitals, etc.

Although the Metropolitan Toronto area has many mental health facilities and services, waiting lists for appointments in the various clinics are extensive. Several of the medical officers of health expressed the opinion that additional mental health clinics were needed in their areas. At least two of the larger suburban municipalities wish to have local mental health clinics established in the near future.

Industrial Hygiene

Metropolitan Toronto is an active industrial centre containing many diversified industries. The employed labour force is scattered throughout the entire area and many people work in municipalities other than that in which they reside. Many larger industries provide a medical and nursing service for their employees; others provide nursing and first-aid service only; some, of course, provide no service.

The Industrial Hygiene Division of the Ontario Department of Health has a staff of physicians with special training in industrial medicine, as well as physicists and other specially trained personnel. The services of these specialists are available to local health departments and to industry for consultation and advice.

The role of the local health departments in the field is principally one of assistance in certain programmes, such as group immunization of employees. Public health nurses in a local health department may be requested to make home visits to sick employees. Industrial nurses frequently seek assistance from their local health department in preparing educational programmes in the field of accident prevention, immunization, etc. Audio-visual materials, such as films, posters, and pamphlets are supplied on request. Local health departments also make the services of their sanitation staff available to industry. The inspectors may advise on cafeteria facilities or other matters in the field of environmental sanitation.

Care of the Aged

Only the Scarborough Health Department in Metropolitan Toronto provides a clinic for the routine examination of older people. Any resident over 50 years of age may receive an appointment for a complete medical history, physical examination, and certain routine chemical laboratory tests. In the other municipalities the Health Departments co-operate with private physicians and hospital out-patient departments in providing public health nursing services for the elderly in the home. Bedside home nursing is provided by the visiting nurses of the Victorian Order of Nurses and the St. Elizabeth Nursing Association. The City of Toronto has a Pilot Home Care Programme serving selected cases, including older people.

The generally expressed opinion of the personnel of the local Health Departments in the Metropolitan Toronto area is that the following provisions are needed for elderly people living at home:

1. Bedside nursing service.
2. Homemaker service if only for a short period each day or even two or three days a week.
3. Apartment dwellings with central dining rooms to provide adequate meals.
4. Friendly visiting by members of the community.
5. Travelling library facilities for "shut-ins".
6. "Meals on Wheels", a house-to-house hot meal service.

The problems of this age group are being brought to the attention of the local Health Departments with increasing frequency, and efforts are being made to find solutions to their common health problems.

Relationship with Other Agencies

Medical Officers of Health are not members of any hospital boards in the Metropolitan Toronto area but some of the full-time ones are on the staff of local hospitals, either as members of the consulting or courtesy staff. Others have no official staff appointments but are consulted on special public health problems which may arise in a hospital. Those part-time health officers who are in active practice usually have staff appointments in a local hospital. Some health officers have teaching duties in the hospital schools of nursing.

There are a great many voluntary and semi-official agencies in the health and welfare field in Metropolitan Toronto and all the Medical Officers of Health are associated with their programmes to some degree. There are close working arrangements with the Ontario Society for Crippled Children, the local Cancer Societies, Children's Aid Society, Red Cross Societies, Canadian National Institute for the Blind, the Family Service Bureau, and the Visiting Homemakers Association, to mention but a few. The public health nurses, in particular, have considerable contact with these agency programmes.

OTHER ORGANIZED COMMUNITY HEALTH SERVICES

Except for the public health departments which were visited, time did not permit visits to the many individual programmes, facilities, and agencies in Metropolitan Toronto, as was done in the field studies described in Appendixes I to III.¹ Data on these were obtained from the extensive existing sources of information, in particular, the numerous publications of the Social Planning Council of Metropolitan Toronto, including those related to the General Needs and Resources Study, 1961-1963,² and the various reports on hospital needs of the Committee for the Survey of Hospital Needs in Metropolitan Toronto, 1961-1963.³ These are public documents and reference should be made to them for specific details on individual programmes and services.

¹ There are over 100 organized programmes related to health in Metropolitan Toronto.

² *A Study of the Needs and Resources for Community-supported Welfare, Health, and Recreation Services in Metropolitan Toronto*, Toronto: Social Planning Council of Metropolitan Toronto, 1963.

³ See Bibliography, pp. 325-328.

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BIBLIOGRAPHY

PUBLIC DOCUMENTS AND REPORTS

- Canada. Department of National Health and Welfare, Research and Statistics Division. *The Administration of Public Health in Canada*. Health Care Series, Memorandum No. 3, 1958.
- . *Health Services for Public Assistance Recipients in Canada*. Health Care Series, Memorandum No. 1 (2d. edition), 1959.
- . *Hospital Care in Canada, Recent Trends and Developments*. Health Care Series, Memorandum No. 12, 1960.
- . *Public Health and Welfare Services in Canada, a Report Prepared for the Canada Year Book 1962*. 1962.
- Canada. Department of National Health and Welfare, Mental Health Division. *Community Outpatient Mental Health Services in Canada*. 1960.
- Canada. Department of National Health and Welfare. *Report of the Survey of Health Unit Services in Eight Provinces of Canada 1960*. 1961.
- Canada. *Annual Report of the Minister of National Health and Welfare under the Hospital Insurance and Diagnostic Services Act for the Fiscal Year Ended March 31, 1962*. 1962.
- Canada. Dominion Bureau of Statistics, Health and Welfare Division, Institutions Section. *Mental Health Statistics 1959*. 1961.
- . *List of Canadian Hospitals and Related Institutions and Facilities 1962*. 1962.
- Canada. Dominion Bureau of Statistics, Health and Welfare Division, Public Health Section. *Statistics of Home Nursing Services (Victorian Order of Nurses for Canada) 1960*. 1962.
- Ontario. Department of Municipal Affairs. *1962 Municipal Directory*. Toronto: 1962.
- Ontario. Ontario Department of Economics. *The Northeastern Ontario Region Economic Survey*. Toronto: 1961.
- Ontario. Ontario Department of Economics and Development. *The Lake Ontario Region Economic Survey*. Toronto: 1961.
- Saskatchewan. *The Report of the Advisory Planning Committee on Medical Care to the Government of Saskatchewan*. Regina: 1963.
- Saskatchewan. *The Report of the Committee on Aging and Long-Term Illness*. Regina: 1963.
- Saskatchewan. *The Hospital Survey Report*. Regina: 1961.
- United States. Department of Health, Education, and Welfare. Public Health Service. *Medical Care in the United States, The Role of the Public Health Service*. 1961.
- New York State. Department of Health. *Professional Education for Public Health Personnel in New York State*. 1961.
- Relevant Dominion, provincial, and municipal legislation and regulations.
- Annual reports of various provincial departments of public health and of the hospital authorities.
- Submissions and briefs to the Royal Commission on Health Services.

BOOKS

- Bryce, Peter H. *The Story of Public Health in Canada in A Half Century of Public Health*. Edited by Mazyak P. Ravenal. New York: American Public Health Association, 1921.

- The Federal and Provincial Health Services in Canada*. Edited by R. D. Defries. (2d. edition revised). Toronto: Canadian Public Health Association, 1962.
- Heagerty, John J. *Four Centuries of Medical History in Canada*. Toronto: The Macmillan Company of Canada Limited, 1928.
- McNerney, Walter J., and Riedel, Donald C. *Regionalization and Rural Health Care, An Experiment in Three Communities*. Ann Arbor: University of Michigan, Graduate School of Business Administration, Bureau of Hospital Administration, Research Series, No. 2, 1962.
- Mott, F. D., and Roemer, M. I. *Rural Health and Medical Care*. New York: McGraw Hill, 1948.

ARTICLES AND PERIODICALS

- Barter, Marion I. "The Pilot Home Care Program of Toronto", *Canadian Journal of Public Health*, Vol. 54, No. 2 (February, 1963), 55.
- Breslow, Lester: "The Role of the Local Health Department in Medical Care", *Canadian Journal of Public Health*, Vol. 53, No. 1, (January, 1962), 1.
- Dale, B. T. "Home Care Needs in Wellington County", *Canadian Journal of Public Health*, Vol. 53, No. 11 (November, 1962), 452.
- "Extension Course for Training Medical Record Personnel, Technicians, and Clerks", *Saskatchewan Hospital Association Bulletin*, No. 51 (January, 1963).
- The Globe and Mail*. (Toronto). February 22, February 27, and March 1, 1963.
- "Half Our Hospitals Don't Get Official Okay", *The Financial Post*. (Toronto), Vol. LVI, No. 5 (February 3, 1962), 21.
- Hastings, John E. F. "Rehabilitation and the Public Health", *Canadian Journal of Public Health*, Vol. 53, No. 7 (July, 1962). 279.
- Hastings, John E. F. "Issues and Priorities in Health Care", *Selected Papers No. 3*, (The Canadian Welfare Council), 1961.
- MacGregor, Stewart A. "Rural Ontario and Its Health Problems", *The Journal of the Ontario Dental Association*, Vol. 40, No. 1 (January, 1963), 8.
- Martin, G. K. and Ladd, K. B. "Maternal and Child Health Services, Ontario, 1958", *Canadian Journal of Public Health*, Vol. 51, No. 3 (March 1961), 111.
- Neal, May. "United for Action", *Canada's Health and Welfare* (December, 1962), 4.
- Percy, Dorothy M. "Organized Home Care", *Canada's Health and Welfare* (December, 1960), 2.
- Terris, Milton. "The Future of Community Health Services", *Public Health Reports*, Vol. 77, No. 10 (October, 1962), 849.

REPORTS AND PAMPHLETS

- Association of State and Territorial Health Officers. *A Long Range Planning Guide for Health Officers*. 1961.
- Canadian Association of Occupational Therapy. *Special Course in Occupational Therapy*, Toronto.
- Canadian Council on Hospital Accreditation. *Accredited Canadian Hospitals*, December 31, 1962. (Mimeographed).
- Canadian Hospital Association and Canadian Association of Medical Record Librarians. *Extension Course for Training Medical Record Personnel*. 1962.

Canadian Hospital Association. *Canadian Hospital Directory*, 1962. Toronto: 1962.

Canadian Mental Health Association. *Mental Health Facilities in Toronto*. A Report of the Local Board of Health. Toronto: 1961.

Canadian Public Health Association, Regulations. *The Certificate in Sanitary Inspection*. C.S.I. (C).

Canadian Society of Laboratory Technologists, *Medical Technology, a Career with a Future*. Hamilton: 1959.

———. *Approved Hospitals for Training Medical Technologists*. 1961. (Mimeographed).

Committee for Survey of Hospital Needs in Metropolitan Toronto. *Active Treatment in Hospitals in Metropolitan Toronto*. Part Five of a Study by the Committee for Survey of Hospital Needs in Metropolitan Toronto. 1963.

———. *Hospital Accommodation and Facilities for Children in Metropolitan Toronto*. Part Six of a Study by the Committee for Survey of Hospital Needs in Metropolitan Toronto. 1962.

Dale, B. T., and Mumby, D. M. *A Study of Home Care Needs in Wellington County*. The Wellington County Board of Health, 1961.

Hastings, John E. F. *Report to the Toronto Labour Health Centre Organizing Committee*. Toronto: The Toronto Labour Health Centre Organizing Committee, 1962.

Ontario Dental Association, Ontario Dental Public Health Council. *Workshop Conference on Dental Health Services to the Public in Rural Ontario Communities*. 1962. (Mimeographed).

Ontario Department of Health. *The Certified Nursing Assistant Program in the Province of Ontario*. 1961.

———. *Centres for Certified Nursing Assistants in Ontario under the Nursing Act*. 1962.

———. *Occupational Therapy Assistant's Course*, Ontario Hospital Kingston. 1961. (Mimeographed).

Ontario Hospital Association. *Approved Schools of Study in Ontario* (for Dietitians, Medical Laboratory Technologists, Medical Record Librarians, Medical Social Workers, Nursing, Certified Nursing Assistants, Physical and Occupational Therapists, Radiological Technicians). 1962.

———. *A Further Proposal for Training Food Supervisors*. 1962. (Mimeographed).

———. *In the Service of Others—Hospital Careers*.

Ontario Society on Aging. *A Guide to Legislation and Services Related to the Well-being of Older People in Ontario*. 1962. (Mimeographed).

Social Planning Council of Metropolitan Toronto. *Directory of Community Services, Health, Welfare, Recreation*. 1962.

———. *Inventory of Rehabilitation Services in Metropolitan Toronto*. 1960. (Mimeographed).

———. *Report of Committee on Survey of Services for Older People in Metropolitan Toronto*. 1961. (Mimeographed).

———. *A Study of the Needs and Resources for Community-supported Welfare, Health, and Recreation Services in Metropolitan Toronto*. 1963.

Also working documents used in the study.

UNPUBLISHED MATERIAL AND OTHER SOURCES

- Hastings, John E. F. "The Role of Voluntary Health Agencies". Address to annual meeting of the Muscular Dystrophy Association of Canada. 1963. (Mimeographed).
- . Personal interviews and records of visits to United Kingdom, Norway, Sweden, Denmark, U.S.S.R., India, Ceylon, and Japan under the auspices of the World Health Organization, 1960.
- . Personal interviews and records of visits to selected group practice prepayment plans in the United States under the auspices of the Toronto Labour Health Centre Organizing Committee, 1961.
- Mennie, W. A. *Fact Sheets Prepared for the Royal Commission on Health Services*, Ottawa: Department of National Health and Welfare, Research and Statistics Division, 1962.
- Neilson, John B. Summary of an address to the Social Planning Council, Health Section. 1961. (Mimeographed).
- Data supplied by organizations and agencies studied.

